

DEVELOPMENT OF A COMPETENCEY FRAMEWORK  
AND TRAINING RECCOMENDATIONS FOR STAFF  
WORKING WITHIN SPECIALST MENTAL HEALTH  
SERVICES FOR PEOPLE LIVING WITH DEMENTIA

by

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## **Abstract**

This research was carried out within a large Mental Health Trust in collaboration with a local university. The focus was established by the West Midlands Strategic Health Authority who agreed to pay the Trust to undertake an evaluative project to establish:

- 1) Training competencies required to deliver dementia care in line with current NHS dementia care policy and;
- 2) To gather evidence on staff views of learning and skill development in order to give recommendations on the delivery of training.

To achieve the primary aim a systematic review of the literature was undertaken, interviews were conducted with 30 key clinical leads and a short qualitative semi-structured survey was also conducted with a range of staff (n=26) from across the service. In order to achieve the second aim a methodological approach based on phenomenology was used in order to explore the experiences of staff and caregivers, involving 14 focus groups with 70 participants in total.

The findings showed that staff perceived a wide range of competencies to be required for a specialist service. These were divided into those necessary for three specific levels of practice: Generic, Specialist and Advanced. A competency framework was generated which combines recommendations from existing competency frameworks with responses from the study samples. The project also provides a view of staff's training requirements and evidenced recommendations for training and education.

Five themes relevant to training needs and delivery of training emerged from the focus groups. These included competency based skills, beliefs around person-centred care, enablers and barriers to delivering person-centred care and ways of learning. The findings suggested a problem-based experiential approach might meet the needs of care staff to provide opportunities for “learning by doing”, “learning by experience” and “learning from each other”. It was proposed that this could include opportunities for role modelling, collaboration and for deep learning in practice, which would lead to better outcomes than training days away from the clinical area.

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## **OVERVIEW**

It is conservatively estimated that 700,000 people in the UK have Dementia (National Dementia Strategy, 2009). Dementia costs the UK 17 billion a year and according to the National Dementia Strategy (NDS) (2009) in the next 30 years this will treble to over £50 billion a year. The prevalence rates obtained vary significantly from 2.3% of 65-70 year olds to 17.5 % of over 80 year olds (Bowie and Takrit, 2004). An overall rate of 5% is suggested in the population aged 65years and over (Bowie and Takrit, 2004).

The National Dementia Strategy (2009) identifies the need for raising competency across health, social and third sector provision for care of people living with dementia. Following the implementation of the Dementia Strategy, dementia services are currently undergoing a transformation process, with the development of new roles such as “Dementia Pathway Co-ordinator” and “Primary Care Liaison Worker” and functionalised services including Assertive Outreach, Memory Assessment Teams and Primary Care Liaison.

These changes will present competing demands on staff working within specialist mental health services, therefore effective education and training is needed to build capacity and improve staff’s knowledge and skills in order to respond successfully to these challenges. Central to this process is the preparation of staff for a new service, to ensure that they have the skills to meet the needs of people living with dementia and those of the people who care for them within the new service model.



This research was conducted within a large NHS Trust in collaboration with a local university. The Trust responded to government policy and was seeking to identify the training needs and competencies for staff working within a specialist mental health service, in order to ensure that staff are equipped with the necessary knowledge and skills so they are able to ensure people with dementia receive the highest possible care. The researcher was commissioned to peruse this, and within these broad aims the researcher was able to decide on the means of investigation and method. She was responsible and accountable to the clinical director of the service and the Strategic Health Authority (SHA) who funded the project.

This thesis describes the development of a competency framework for staff working within a specialist mental health service. It also provides a picture of staff's training requirements and evidenced based recommendations for training and education which is responsive to both staffs' needs and the requirements of key stakeholders and NHS Trusts which provide specialist mental health care for people living with dementia.

The thesis is set out in 4 chapters. Chapter 1 includes a systematic literature review of the research and educational literature on training and competencies for dementia care. A critique of the literature follows and this leads to the researchers' conclusions and a rationale for the current investigation. This chapter also includes key definitions and an overview of current government policy. Chapter 2 addresses the method and results of the interview and survey study. This aimed to find out, from a range of professionals in mental health, the competencies they used or those they felt were required in dementia care. Chapter 3 addresses the method and results of the focus groups which explored the roles of staff and caregivers in order to develop

recommendations on delivery of training for staff working within specialist dementia services. Finally chapter 4 links the findings to previously discussed theory and research. This chapter also includes reflections and analysis of the experience and suitability of the research approach. Recommendations are also discussed for staff training based on problem-based approaches and experiential active learning. Opportunities for accelerating the spread of good practice are also identified such as role modelling and maximising opportunities for collaborative learning.

## **Chapter 1**

### **LITERATURE REVIEW**

In the following chapter I will define key terms including competence, specialist mental health services and dementia including associated approaches to care. An overview of government policy in relation to people living with dementia will also be undertaken. Following this a review of the literature will be presented offering a rationale for the research questions. The review will focus on the development and evaluation of educational programmes for staff. Following this I will examine the development of competency frameworks for staff working within the health care sector.

#### **Key Terms**

##### **Dementia**

Dementia is a clinical syndrome evidenced through a set of symptoms that include decline in memory and thinking, present for six months, of a degree sufficient to impair functioning in daily living (Knapp, 2007; NDS, 2009). Of all the causes of dementia Alzheimer's disease represents 50% of cases and has attracted the most public attention and research effort.

In the last decade or so psychosocial understandings of dementia have emerged to challenge the previously dominant biomedical understandings, which focus on disease processes only. Kitwood (1987, 1988) was at the forefront of challenging the biomedical understanding of dementia and his approach is situated within a

bio-psychosocial framework emphasising individual psychology and social relationships in addition to the neurological and health factors. Kitwood argues that brain pathology and brain function only contribute partly to the experience of dementia and other factors need to be considered. Each person may therefore have a different experience of dementia regardless of similarities in brain pathology. Kitwood considered from a psychosocial perspective that an understanding of dementia must include not only the biological and pathological but also incorporate individual psychological and social aspects which impact on the experience of dementia. Therefore in offering interventions for people living with dementia there is a need for a holistic “person-centred” focus.

Williams and Grant (1998) believe that person-centred care requires knowledge of individuals, exploring and recognising their ideas, beliefs and lay knowledge. Mulrooney (1997) extends the criteria for person-centred care, identifying three attributes: Respect for personhood, valuing interdependence and investing in care-giving as a choice. Various definitions of person-centred care have been proposed, with one of the most well known being Brooker’s (2007) VIPS model. Brooker (2007) explains the four key elements of person-centred care as: Valuing people with dementia and those who care for them (V); treating people as Individuals (I); looking at the world from the Perspective of the person with dementia (P); and a positive Social environment in which the person living with dementia can experience relative well being (S).

## Competence

Competence can be defined as “the state of having the knowledge, judgement, skills, energy, experience and motivation that respond adequately to the demands of one’s professional responsibilities” (Roach, 1992, p.18). Other definitions include, “the behaviours employees must have, or must acquire, to achieve high levels of performance”, or “a minimum standard that is demonstrated in performance outputs or standards” (Broady, 2007, p.34). According to Mace (2005) acquired personal skills are competencies and reflect potential ability to provide a consistently adequate or high level of performance in a specific job function. The Agenda for Change generic competencies expected of all health care professionals are captured by the NHS Knowledge and Skills Framework (KSF) (DH, 2004) which includes six core areas of competencies: Communication, personal and people development, health, safety and security, service improvement, quality, equality and diversity.

## Specialist Mental Health Services

Specialist mental health services for older people focus on assessment, diagnosis and treatment of multifaceted cases, providing direct clinical services to those with the most severe and complex mental health difficulties, in combination with problems in other domains (Birmingham and Solihull Mental Health Foundation Trust, 2009). Specialist Mental Health NHS Trusts may have a role throughout the course of a person’s dementia and the complexity is not merely confined to the latter stages. In addition they have an important role in supporting partner organisations in meeting the mental health needs of older people under their care, working alongside mental health services for younger adults, learning disability services, primary care and social and housing services, to deliver an integrated service. The National Service

Framework for Older People (DOH, 2001) states that “specialist mental health services for older people should provide advice and outreach for primary care, residential and nursing homes, sheltered housing, domiciliary care, day care and hospital care” (p55). Specialist mental health services may be required to provide ongoing monitoring and will often intervene in order to manage crises offering support and clinical advice and possibly short-term admission (Adams, 2008). They also tend to have dedicated beds for older people with dementia, as they are at risk on general mental health wards and their pattern of risk and need is different (Daily et al. 2008). According to Daily et al. (2008) mental health trusts tend to reserve beds for patients at the earlier stages of the illness or with relatively few co-morbidities. Although continuing care beds are also required at the latter stages of dementia to provide care for those with challenging behaviour and palliative care.

### Government policy

A number of recent reports have strongly criticised services for older people with dementia. The report “Improving services and support for people with dementia” (National Audit Office, 2007) is disapproving of the management of services and support in the community. The findings demonstrated that specialist mental health services lack of knowledge and skills in managing older people’s physical health needs and suggest that Community Mental Health Teams (CMHTs) need to improve skills of their members to support those with frailty or physical need. The report states that if a person with dementia suffers from a health crisis such as a fall or infection, admission to acute hospital is often the only option, even if the medical need is not very acute. The report also found that a quarter of Community Mental Health Teams (CMHTs) have little or no coordination with other primary care providers. Poor co-

ordination means people with dementia, who may not be able to manage their own services, could not be getting the appropriate care and as a result they may feel stressed and marginalised. The majority of CMHTs do not have formal outreach teams within Accident and Emergency departments or the acute medical specialities. The National Audit Office (2007) states that CMHTs need to improve their range of skills to take the lead in case management.

The Alzheimer's Society's report "Counting the cost: Caring for people with dementia on hospital wards" (2008) found unacceptable variation in the quality of dementia care provided on general wards in hospitals around the UK. The report states in the long term, "dementia-specific education is required to empower and inform hospital staff". As part of the report the Society conducted a large survey of 1,291 carers, 657 nursing staff and 479 nurse managers. There were a number of key findings including: 77% of carer respondents were dissatisfied with the overall quality of care and 89% of nursing staff respondents identified working with people with dementia as "very" or "quite challenging". The main areas of dissatisfaction as identified by carer respondents were: Nurses not recognising or understanding dementia; a lack of person-centred care, not being helped to eat and drink, a lack of focus for social activities and limited involvement with decision making. Key areas of concern for the staff were: Managing challenging behaviour, communicating, not having enough time to spend on one-to-one care and wandering. A number of recommendations were made within the report, such as reducing the number of people with dementia being cared for in hospital, hospitals to identify a senior clinician to take the lead for quality improvement and for defining the care pathway, commissioning of specialist older people's mental health teams to facilitate the management and care of people with

dementia in hospital, ensuring there is an informed and effective acute workforce in hospitals for people with dementia and reducing the use of antipsychotic medication.

In response government policies have suggested a greater emphasis on certain sorts of developments in the care pathways, such as early intervention or in-reach. The National Dementia Strategy (NDS, 2009) sets out plans to ensure significant improvements are made to dementia services across three key areas: earlier diagnosis and intervention, and a higher quality of care. The strategy identifies 17 key objectives which, if implemented, should result in significant developments in the quality of services provided to people with dementia and promote a greater understanding of the causes and consequences of dementia. Themes include raising awareness and understanding, early diagnosis and support, living well with dementia and delivering the strategy. The strategy calls for leadership for dementia in general hospitals, a care pathway in hospital and specialist liaison teams for older people. The strategy also focuses on improving quality of care for people in care homes by the development of explicit leadership for dementia within care homes, defining care pathways there, the commissioning of specialist in-reach services from community mental health teams and robust inspection regimes.

The Darzi Dementia Clinical Pathway group for the West Midlands (Sadd et al. 2008) proposed a regional dementia pathway setting out eight standards, which if met, will help achieve their vision of a “seamless, proactive and high quality locality based service” (p. 10). These included that health and social care services should jointly plan and commission a service for people with dementia and their carers, specifying services for dementia which will interface with services available for all other long



term conditions for older people. They also recommend that minimum core standards of competency for dementia care should underpin education programmes for staff working with dementia. The group also called for a “Memory Assessment Service” with an integrated health and social care team within every Primary Care Trust.

Government policies advocate the development of new roles to improve access to services. The Darzi Dementia group included plans for two new roles: “Primary care liaison workers” and a “Dementia Pathway Coordinator” (Sadd et al. 2008). The aim of these new roles is to assist service users and their carers to navigate services and enable funding to follow the service user (Sadd et al. 2008). The NDS (2009) also proposes new roles in order to achieve a more integrated service. The strategy refers to “Dementia Advisors” who will facilitate easy access to care, and offer support and advice following diagnosis, providing an essential link for patients and families from point of diagnosis throughout the patient’s journey.

However according to Woodward (2008) there is a lack of specialist nurses who can perform these new roles. Woodward (2008) argues that while post-qualification training in specialist care will be required, there is also a need for greater inclusion of aspects of dementia care within the pre-registration nursing curriculum. Currently professional training for medical and nursing staff includes little or no coverage on the topic of dementia (National Audit Office, 2007). Developing professional dementia training is therefore a key issue to ensure that nurses have the appropriate skills to care for these vulnerable patients (Mooney, 2009).

Government policy suggests that health and social care staff involved in the care of people living with dementia should have the necessary skills to provide the best quality of care and this is to be achieved by effective basic training and continuous professional and vocational development (NDS, 2009). Hence overall most of these policies highlight the need for a competent workforce and argue there are new competencies required in light of changing services-thus the need for a competence framework and to know how to skill up the workforce.

#### Literature review of the effects of educational strategies in the field of dementia

The following section aims to review research literature which has been conducted with the aim of surveying the content and assessing the effects of educational programmes for staff in the field of dementia care. Attention is paid to how these educational interventions were developed, if this aspect is described in the paper.

A literature search was carried out of publications between 1990 and 2010 using the following databases: Psycinfo, CINAHL, BNI, EMBASE, and MEDLINE. The key search terms were, “Alzheimer’s disease” or “Dementia” in conjunction with “Training”, “Education” and “Mental Health Personnel”. (Variants and \$ were used). (See Appendix 1 for search strategy). For inclusion studies needed to meet the following criteria: (1) Educational interventions which focused on the management of dementia (2) Study designs which included randomised controlled trials or controlled before-and-after studies using validated quantitative outcome measures (3) Study designs with qualitative methodology. The methodological quality of these studies was taken into account during the data synthesis. Small scale qualitative studies which

were reflective accounts, where method and design were not discussed, were therefore excluded.

On the basis of titles and abstracts all the studies that clearly did not meet the inclusion criteria were excluded from the review. Of the remaining papers, full text articles were reviewed and assessed for possible inclusion. The references from these papers, including two systematic reviews (Livingston et al. 2005 and McCabe et al. 2007), were also hand searched and the full texts were requested if relevant. In addition leaders in the field from 3 UK centres of excellence were contacted with a view to identifying key papers. In total 21 studies were identified. However, 9 of these were then excluded as being of poor quality. Quantitative studies were excluded if they only used measures following training rather than before and after training. Studies were also excluded if the focus of the training was not on management of dementia, e.g. if the study focused on detection rather than management. Although the researcher sought to be as consistent as possible in applying the inclusion/exclusion criteria, there is inevitably an element of subjectivity". This left 11 studies which met the eligibility criteria. The literature will be discussed in relation to the effects of, and development of, educational interventions in dementia care under two sub headings: Firstly, RCTs and before-and-after studies using quantitative outcome measures and secondly study designs with qualitative methodology.

A systematic review conducted by Livingston et al. (2005) on psychological approaches to treating the neuropsychiatric symptoms of dementia included nine studies which involved psycho-education to teach caregivers how to change their interactions with patients with dementia. Two of these studies met the current

inclusion criteria are included in this review (Teri et al, 2005; McCallion et al., 1999). The review concluded that there is consistent well supported evidence for the use of staff education in the management of neuropsychiatric symptoms. However improvements in knowledge and skills were not always sustained over time.

McCabe et al. (2007) reviewed 19 studies on training programmes to address behavioural problems with dementia among older people in residential care. Many of these studies were the same as those reviewed by Livingston et al. (2005). Overall the results of the review demonstrated that there has been a wide range of psychosocial educational interventions to reduce behavioural problems among older people with dementia, with inconsistent results found in the evaluations (McCabe et al. 2006). McCabe et al. (2006) concludes that there is a lack of consistency in the implementation of education programmes, including the content and training modalities, with research teams implementing various programmes of differing intensity and length, based on different theoretical frameworks, and with a mixed content. While these two other reviews are in an overlapping area they are restricted to particular problems within dementia. These two reviews are restricted to particular problems within dementia. The review conducted by Livingston et al. (2005) was on teaching psychological approaches to carers to manage 'neuropsychiatric symptoms of dementia' while McCabe et al. (2007) focused on challenging behaviour only. The current review aimed to cover papers across the breadth of dementia care and update the literature.

### Randomised controlled trials and study designs with quantitative outcome measures

Chenoweth et al. (2009) carried out a cluster RCT comparing person-centred care (CADRES), dementia mapping and usual care in dementia. The study was carried out in New Zealand and Australia. Fifteen urban residential sites with 289 patients were randomly assigned to person-centred care, dementia care mapping or usual care. Carers received training and support in either intervention or continued usual care. The assessors were blind to the treatment allocation. The primary outcome was the residents' behaviours. Outcome measures were assessed at baseline and directly after the of intervention, and at 4 months follow up. These were administered independently by research assistants who remained masked to group intervention by means of a signed agreement with staff and managers not to mention the intervention, by ensuring that questionnaires included no intervention information, and by regularly checking with the research assistants that they remained unaware of treatment allocation throughout the study. The Cohen Mansfield Inventory (CAMI, Cohen Mansfield and Libin, 2004) score was significantly lower following the intervention, therefore demonstrating a reduction in agitation, in sites providing mapping and person-centred care, compared with usual care. Fewer falls were recorded in sites that used mapping but there were more falls with person-centred care. There were no other significant effects reported. According to Ballard (2009) CADRES is an extremely important trial that may greatly affect clinical practice. However the study has some limitations. Firstly, the comparison of the interventions with usual care is problematic because there are probably non-specific benefits from any intervention. An education-alone intervention might have been a preferable comparison group. Secondly, the duration of the intervention was brief. Longer treatment and follow up are needed to determine the impact of educational interventions on clinical practice. Thirdly, the

lack of benefit for psychiatric and behavioural symptoms other than agitation or psychotropic drugs was disappointing (Ballard, 2009). According to Ballard (2009), as in other trials in dementia care, direct improvement in quality of care home residents was rare.

Kuske et al (2009) carried out a 3 arm cluster RCT in Germany in order to examine the effectiveness of a staff training programme designed to improve interaction between residents with dementia and their caregivers (i.e. paid staff) within nursing homes. The sample consisted of 96 caregivers and 210 residents. The caregivers who were randomized to the intervention group received a 3 month training programme in dementia care. Data was gathered at baseline, immediately after training and after 6 months. The study attempted to measure the staff's sensitisation to the experience of the residents with dementia and their communication competencies. A range of standardised outcome measures was used to assess rates of staff burnout and staff's knowledge and competence in dealing with challenging behaviour. Knowledge and competencies were assessed using the GEROLF staff questionnaire (Zimber, 2003). The GEROLF is a German benchmarking instrument to measure the quality of life of patients in nursing homes. A staff questionnaire was based on the Penn State health Care-giving Questionnaire (MHQ; Spore et al. 1991) and was used to measure caregiver's level of knowledge. Burn-out was assessed using the Maslach Burnout Inventory (MBI-D; Bussing et al, 2003). Assessment measures were administered independently by either a psychologist or supervised research assistants, who were blind to treatment allocation. The programme and development of training content was based on the findings of a comprehensive literature search (Kuske et al. 2007) and a focus group which included 12 caregivers from three nursing homes. A key

focus was to improve caregiver's knowledge as well as their competencies for managing patients with dementia. There were 5 modules including an introduction explaining the training content, and modules looking at dementia, person and environment, communication and finally completion and feedback. The focus of the education was to develop the abilities of reflection and independent problem-solving. The intervention consisted of 13 one hour sessions of training over 13 weeks, delivered in small groups of 12 caregivers.

The findings suggested significant positive effects of the training programme on caregivers' overall competence in managing patients with dementia and a reduction in the use of neuroleptic medication. However this effect was not sustained at the six month follow up. Interestingly the authors feel this effect supports the assumption that ongoing support, changes in working conditions and more time for the residents beyond basic physical care, as well as other organisational or environmental changes, are necessary to facilitate the implementation of newly learned skills (Cohen-Mansfield, 2001; Aylward et al. 2003; Kuske et al. 2007). The study had several strengths including a six month follow up assessment to detect long term effects; the training impact was measured with respect to both staff and residents and an RCT design was used. The study's most important limitations are associated with the barriers presented by the nursing home setting as it was not possible for caregivers to be blind to the treatment conditions.

Visser et al. (2008) conducted a RCT to evaluate effectiveness of staff education and peer support in Australia. The study was designed to investigate the impact of staff education on the behaviour and quality of life of residents with dementia and on

staff's attitudes about working with people with dementia and level of burnout. Fifty-two staff from 3 nursing homes participated in the study. These homes were randomly assigned one of two intervention groups or a control group. Staff assigned to the intervention groups received an 8 week behaviourally based programme. Staff from one home also participated in a peer support group designed to reinforce the educational material. The CMAI was used to measure behaviour; other standardised scales were also used to measure quality of life, staff attitudes and level of burnout. The measures were administered independently by a research worker, who was blind to the allocation of the intervention, throughout the study. These were administered pre and post intervention and at six month follow up. Visser et al. (2008) do not describe the development of the programme which consisted of eight 1 hour units. Three of these were didactic and the remaining 5 were facilitated workshops that were based on a behavioural model, focused on understanding antecedents and consequences of behaviours (ie. an A-B-C model). During the workshops staff members developed individualised care plans for residents monitoring the antecedents and consequences of behaviour and modifying them appropriately (Visser et al. 2008). The paper does not state if these workshops were delivered in the workplace or elsewhere.

The results demonstrated that neither education nor education plus peer support was not associated with an improvement in resident behaviour or quality of life. Also education or education plus peer support did not impact on staffs' level of burnout; however the results did show a change in staffs' attitudes to working with people with dementia. The study has several limitations as the sample sizes were small and the residents' behaviour was rated by the staff members who cared for them and who



were involved in the education programme. The authors suggest that the lack of positive impact of the training might have been due to organisational factors, as they report that staff had difficulty attending education (e.g. participating in their own time and negotiating time away from resident care) suggesting management support was low. According to Visser et al. (2008) staff education offered in isolation from the socio-cultural context within which staff members' work may not be an effective way of managing behavioural symptoms in dementia.

Fossey et al. (2006) conducted an RCT to evaluate the effect of enhanced psychosocial care on antipsychotic use in nursing home residents with severe dementia. Twelve specialist homes for people with dementia in the UK were included and patients were randomised to a training and support intervention or usual treatment. The intervention focused on the delivery of person-centred care and skills development in training and supervision. Staff were supervised weekly over the study period (12 months). The programme was also supported through classroom based didactic training, skills modelling and supervision of groups and individual staff. Key elements included skills training, behavioural management techniques and ongoing training and support. The CMAI was used to measure reported agitated and disruptive behaviours and Dementia Care Mapping was used to develop the practice of person-centred care. Follow up assessments were carried out immediately after and at 12 months by a researcher who was blind to the treatment intervention. The results demonstrated a substantial reduction in the use of neuroleptics, however no significant differences were found between the intervention and control groups in levels of agitation at 12 months. Ratings for wellbeing in residents in the intervention group were similar to those in the control group. According to Fossey et al. (2006) failure of

the training and support intervention to have a significant effect on any of the secondary outcome measures may reflect difficulties inherent in the culture of care within nursing homes enabling change to be measured in such a small scale trial. Compared to many of the studies reviewed the treatment intervention in the Fossey et al. (2006) study was substantially longer and more intensive as staff were supervised for 12 months (Ballard, 2009).

Teri et al. (2005) carried out a randomised trial in the USA known as the STAR study “A dementia-specific Training Programme for Staff in Assisted Living Residences”. Four assisted living residences were randomly assigned to STAR, or usual onsite training. Twenty-five staff and 31 residents participated in the RCT phase. The training was designed to teach direct care staff in assisted living residences to improve care and reduce problems related with dementia and consisted of two 4 hour group workshops, augmented by four individualized on site consultations and 4 leadership sessions. The STAR model appears to be based on “person-centred care” and is supported by an integrated model of person-environment fit and social theory. Person-environment fit argues the need for synergy between the person and his/her environment (Teri, et al. 2005). The training also included the ABC model of behavioural distress. The STAR model was developed by means of an iterative process of implementation and revision. A total of 114 staff and 120 residents in 15 residents had participated in the developmental phase.

The study was designed to evaluate changes in patient behaviour, staff skill and confidence. Evaluation consisted of pre and post measures collected 8 weeks after the end of the intervention. The outcome measures were administered directly after the

training and there is no report of any long term follow up. Interviewers blind to treatment condition conducted the pre-training and post-training assessments. The results were positive with statistically significant changes in measures of resident behavioural problems, depression and anxiety. However no statically significant differences were found in staff job satisfaction or sense of competence. The goal of the study was to investigate feasibility of the intervention therefore the RCT phase of the study had limited power as the sample size was relatively small (n=25). It appears that the studies conducted by Fossey et al. (2006) and Visser et al. (2008) may have failed due to the lack of fit between the organisational factors and the training, and it is possible that Teri et al. (2008) succeeds because of the attention to person-environmental fit.

Testand et al. (2005) conducted a single-blind controlled trial in Norway. Four homes were randomised to a control or training intervention group. Data were collected before and after the intervention by an independent rater who was blind to treatment allocation. The outcome measures were behaviour and use of restraints. The intervention consisted of a full-day seminar, which focused on dementia awareness, followed by a one-hour session of guidance per month over 6 months covering behavioural management techniques. The findings showed the use of restraints had declined in the treatment group; however the level of agitation remained unchanged. Limitations included a small sample size; in addition no long-term follow up data was collected.

Featherstone et al. (2004) carried out a UK based controlled intervention that examined the impact of a brief 6 week training programme including 40 unqualified care workers and 4 EMI homes and control homes. The training approach used an integrative methodology combining components of cognitive behaviour therapy, challenging behaviour training and experiential learning. Four reliable and well validated questionnaires were used to assess staff thoughts and attitudes towards people displaying challenging behaviour, staff knowledge of dementia and general coping style. These were self-administered questionnaires and both the staff in the control group and the homes which received training were asked to complete these pre and post training. The results indicated that the training programme had a significant impact on the staff's knowledge base and attitude, however there was no evidence that staff's coping skills improved. Featherstone et al (2004) stated that the work has important implications for the development of primary care/liaison services as it suggests that lightly resourced interventions are able to produce a significant change in staff's learning and attitudes. Limitations included the small sample size was small and a RCT design was not used. It is interesting to note Featherstone et al. (2004) acknowledge that the results could be attributed to the trainer, which may be also confounding factor in other studies. In addition, none of the outcome measures focused on the behaviour, well-being or care of the people with dementia.

Schrijnemakers et al. (2002) implemented an RCT of an emotion-focused education programme in the Netherlands. The effects of emotion-oriented care on the behaviour of elderly people, with cognitive impairment, and behavioural problems were investigated. The approach was mainly based on the validation approach, but also uses insights from other approaches like reminiscence and sensory stimulation.

Sixteen nursing homes and day care units were randomly allocated to an intervention or control group. One hundred and fifty one residents with cognitive impairment and behavioural problems were included in the study. The eight intervention homes received a training program with regard to emotion-oriented care. In the eight control homes usual care was continued. Standardised valid and reliable measurements were performed at baseline and after 3, 6 and 12 months of follow-up. These were administered by an independent rater blind to treatment allocation. The primary outcome measure was the change in behaviour of the residents but Schrijnemakers et al. (2002) did not find any change in neuropsychiatric symptoms or behaviour.

Woods and Lintern (2000) conducted an uncontrolled evaluation of training in the UK, using quantitative measures pre and post training. Thirty-four care assistants from a 50 bedded home participated in the study. Half the staff were trained at a time, with an interval of 3 months between the first and second staff groups receiving training. There were two training interventions: a two day training course for senior staff and a two day training course for care staff. The training focused on the development of person-centred dementia care and was facilitated by Dr Tom Kitwood. Attitudes to people with dementia were assessed, together with knowledge. Dementia Care Mapping (DCM) was the main outcome measure assessing the residents' quality of life and well-being. Two independent researchers implemented the DCM. These staff received accredited DCM training and were supervised and assessed for competence during a pilot study. The findings demonstrated no positive effects in resident well-being. The study has a number of weaknesses as a RCT design was not used and no long term follow up data were collected.

McCallion et al. (1999) conducted a RCT in order to evaluate whether a training evaluation designed to improve nursing assistants' communication skills improves the well-being of nursing home residents in the USA. Staff from two nursing homes were randomised to either training as usual or a communication skills programme. A waiting list control design was used. After 6 month follow up the waiting list control group were given the intervention. Eighty-eight nursing assistants participated and measures were also obtained from 105 residents. The development of the communication skills programme is not described in the paper. The training consisted of five 45-minute group sessions and four 30-minute sessions designed to address knowledge, communication, memory aids and problem behaviour.

Measures included staff knowledge of AD, attitudes and turnover rates, as well as resident measures such as signs and symptoms of depression, behaviour and prescribing of anti-psychotic medication. Measures were collected at baseline, 3 months and 6 months. McCallion et al. (1999) found that although there was no improvement in the knowledge of dementia, the programme resulted in reduced staff turnover. The study has a number of limitations, primarily the small number of sites. However according to McCallion et al. (1999) the use of a partial cross over design in the study increases confidence in the findings.

Cohen-Mansfield et al. (1997) carried out an evaluation of an in-service training programme in four nursing homes in the USA. Measures were used to assess nursing staff's knowledge of dementia, behaviour management strategies, staff satisfaction, and their preconceptions of work difficulty and quality of care. A total of 174 nursing staff were enrolled in the study. Assessments were performed by independent raters,

blind to treatment allocation at three time points pre-test, immediately after training and 1 month follow up. The study assessed knowledge of dementia, staff satisfaction and behavioural observations were also performed.

The in-service training was developed with the aid of a nurse educator, based on recent findings from the clinical and research literature. The in-service training lasted approximately 40 minutes. The findings demonstrated improved knowledge immediately following training however this was not sustained at follow-up. Cohen-Mansfield et al. (1997) states the results are owing to limitations of the training which would have been enhanced with repeated training over several months.

#### Studies with qualitative designs

McCarron et al. (2008) carried out a large study in order to understand the experiences of staff in supporting persons with intellectual disability and advanced dementia using mainly qualitative methodology. A cross-section of intellectual disability providers and a specialist palliative care provider in Ireland were involved in the study. A total of 14 focus groups, using non-directive interview guides, were conducted with 57 participants in total. The accounts of their experiences were interpreted to gain an understanding of their education and training needs. This was done with the assistance of qualitative data analysis software. A core theme which emerged from the focus groups which included staff perceptions of the fundamentals of good care at end-of-life for persons with dementia. These perceptions included the belief that person-centred care, comfort and spiritual support are paramount. This information was then used as the basis for an educational intervention which was designed, delivered and evaluated as a pilot effort with 16 staff in these services.

The intervention was developed and implemented by a multi-disciplinary team of trainers. It was designed to respond to the training needs identified by the focus groups, and also took into account recommendations from the literature. The aims were to provide an introductory training programme to support persons working in intellectual disability and specialist palliative care services in order to provide optimal end-of-life care for persons with intellectual and advanced dementia and enable the course participants to support others within their own services. The specific learning aims included person-centred care, decision making and caring for the person, peers, family and staff in relation to quality end-of-life care. The training was made up of 20 sessions with self-directed learning between classroom attendances.

Mc Carron et al. (2008) evaluated the pilot course by measuring pre and post course knowledge and participant satisfaction with the course content and delivery. Formal feedback from staff indicated that the educational intervention was highly valued and addressed key training concerns. The study appears to yield plausible results, as independent experts were used to review the data and give their expert opinion. However the evaluation did not assess whether there had been improvements in care delivery, the sample enrolled in the educational intervention was small (n=14) and no long-term follow-up data was collected.

### Conclusions

The above studies demonstrate substantial variability in the length and type of training interventions that have been evaluated. Indeed there appears to be lack of consistency in the educational programmes, including their content and training modalities, with



research teams implementing various programmes of differing intensity and length, based on different theoretical frameworks, and including many with a mixed content (McCabe et al. 2007). Common areas of focus are person-centred care (though details of how this was operationalised were not always given) and behaviour management but the differing delivery of training in these areas means that it is hard to draw conclusions about whether they impact on quality of care.

A variety of outcomes were measured, with most studies considering impact on staff's knowledge or attitudes and some considering staff behaviour or outcomes for those with dementia. Some of the studies reviewed found a positive impact of training on knowledge and some found changes in staff behaviour (less use of restraints and prescription of neuroleptics). Three found a positive impact on the behaviour of people with dementia, but this was either not sustained or the follow-up period was not long enough to tell if it would be sustained. Almost half of the studies reviewed found no positive changes as a result of the training that had been delivered.

The lack of comparability makes it hard to draw any conclusions at the present time about topics or areas of competence that need to be covered in training for staff working with people with dementia. In addition, it is hard to isolate the key ingredients in success, but some of the findings imply that ensuring training is supported by and embedded in the organisational structures is important and that ongoing support and organisational change may prove necessary to demonstrate a sustained implementation of the new knowledge (Kuske et al. 2007).

It is evident from the review that there is a lack of well evaluated in-service training programmes for health care professionals who are caring for people with dementia. There is also little research which focuses on training for staff within specialist mental health services as the majority of studies were carried out within residential and nursing homes. Therefore there is a need for further well-defined methodologically improved studies particularly within specialist mental health services. This thesis goes on to consider in a systematic fashion the competencies that need to be addressed in such training and the ways such training might best be delivered to ensure that learning is applied and maintained over time to ensure high quality dementia care.

**Chapter 2**  
**DEVELOPMENT OF COMPETENCIES FOR STAFF WORKING WITHIN**  
**THE CARE SECTOR**

**Introduction**

This chapter addresses the secondary project aim which was to develop a competency framework for staff working within specialist mental health services with people living with dementia and their families. The Trust had responded to government policy and was seeking to identify the competencies, knowledge and skills necessary to deliver high quality care. This chapter describes the systematic review undertaken to find out about existing competency frameworks. It goes on to describe the data collection methods used to find out about the opinions of practitioners regarding the competencies required for dementia care, which included interviews and a survey. Following this the methodology used to develop the framework will be described and the competency framework will be presented.

**Literature Review**

A literature search was carried out in order to identify relevant competency frameworks. This was undertaken through major electronic search engines for the years 2004 to 2009 using Psychinfo, CINAHL, BNI, EMBASE, ELITE and MEDLINE. The key search terms included terms around knowledge and skill frameworks e.g. “competencies”, “framework”; terms around dementia and terms connected with the workforce. A total of 22 competency frameworks were identified of which 12 appeared to be relevant for the purposes of the research (see Table 1). These frameworks typically included 12 measurable components and had been

developed using a range of methods, including drawing from national frameworks, job specifications and literature reviews. Other methods included interviews, questionnaires, expert panel discussion or Delphi panels (Tsaroucha et al. 2010). The frameworks identified will be presented in the following passages; the general and generic frameworks will be discussed initially, followed by those which were developed for specialised dementia roles.

The NIMHE published “The Ten Essential Shared Capabilities: A framework for the whole of the Mental Health Workforce” in 2004. This was developed in consultation with service users and carers together with practitioners. Their purpose was to establish the minimum requirements or capabilities mental health staff should possess on completion of training in order to achieve best practice. The capabilities included working in partnership, respecting diversity, practising ethically, challenging inequality, promoting recovery, identifying people’s needs and strengths, providing service user centred care, making a difference, promoting positive risk taking and personal development and learning. The aim of NIMHE was to provide one overarching statement for all staff who work in mental health services.

The Health Professions Council (HPC) is an independent, UK-wide regulatory body responsible for setting and maintaining standards of professional conduct. The HPC have generated standards of proficiency for health care professions including Occupational Therapists (2006) and Physiotherapists (2007), and more recently Practitioner Psychologists (2009). These standards include both generic elements and profession specific elements in 3 domains; knowledge, skills and experience. Other professions such as medics have also developed practice guidelines. The British

Psychological Society (2009) outlines core competencies for clinical psychology which include transferable skills, and those involved in psychological assessment, psychological formulation, psychological intervention, evaluation, research, personal and professional skills, communication and teaching and finally service delivery. The Royal College of Psychiatrists (2009) developed a competency based curriculum for psychiatrists who specialise in old age work. Competencies are arranged under 7 sub-headings; medical expert, communicator, collaborator, manager, health advocate, scholar and professional. These professional frameworks seem to draw on expert opinion from each profession rather than going back to the basics of analysing job content.

Table 1. Competency Frameworks relevant to consideration of dementia care

<b>Author</b>	<b>Framework</b>	<b>Scope</b>
DOH (2004)	Ten Shared Essential Capabilities: a framework for the whole of the Mental Health Workforce	All Health Care Professionals
Health Professionals council The British Psychological Society (2006)	Occupational Therapists (2006) and Physiotherapists (2007)  Core competencies-clinical psychology-A Guide	Examples of generic frameworks which are profession specific frameworks

Royal College of Psychiatrists (2009)	A competency based framework curriculum for specialist training in old age psychiatry	Profession specific framework for psychiatrists working in old age
Skills for Health	Competency for Older People	Generic framework for all staff working with older people
Skills for Care (2005)	Knowledge set for dementia: s	Generic framework for all staff working with people with dementia
Health Care London (2009)	Dementia Integrated care pathway-workforce competencies	Generic framework for all staff working with people with dementia
Tsaroucha et al. (2009)	West Midlands Competencies Framework for Dementia Workers.	Generic framework for all staff working with people with dementia
Adams (2008)	Competencies framework for dementia care nursing based	Framework developed for nursing staff working with people with dementia

Royal College of Nursing (2002)	Admiral nurse competency framework	Framework for Admiral nurse role
Vries et al. (2010)	Workforce Development for Dementia: Development of role, competencies and proposed training for; “Primary care Liaison Worker” to support pathway to diagnosis of dementia.	Frameworks for specific dementia roles
Tsaroucha et al (2010)	Dementia Pathway co-ordinator	

Generic competency frameworks which have been developed for professionals who work with patients with dementia in a wide range of settings include “Skills for Health” (2009) and “Skills for Care” (2005). Both these frameworks were developed following analysis of job specifications. “Skills for Health” was established in 2002 with support from the Department of Health, the independent and voluntary health sectors and staff organisations. Skills for Health takes a UK wide lead for the development and use of integrated competency frameworks across health care working with employers and other stakeholders to ensure that those working in the sector are equipped with the right skills to support the development and delivery of health care services (Skills for Health, DOH, 2009). The framework is intended for Mental Health professionals (2009) and includes a total of 97 different standards

while the framework for Older People includes 3 standards relating to health and well-being, protecting older people from abuse and communication. Skills for Health (2009) states that all health and social care staff involved in the care of people with dementia should have the necessary training and skills to provide the best quality of care in the roles and settings where they work. According to the DOH (2009) this is to be achieved by effective basic training and continuous professional and vocational development in dementia.

Skills for Care is the strategic development body for the adult social care workforce in England. Skills for Care have developed a range of “knowledge sets” which are sets of key learning outcomes for specific areas of work within adult social care. These were designed to improve consistency in the training of the adult social care workforce in England assisting employers, staff and trainers in developing a shared understanding of the necessary knowledge which should underpin social care. Skills for Care (2005) have developed a knowledge set which focuses on dementia. Objectives for learning in this set include supporting individuals with dementia and understanding the need for person-centred care, roles and responsibilities in relation to dementia care, defining dementia (which refers to understanding common types and causes of dementia) and finally legislation and guidance to individuals with dementia.

Healthcare London (2008) has also developed workforce competencies for staff based on the frameworks developed by Skills for Health and Skills for Care, as well as other relevant professional bodies. This includes competencies, for every stage of dementia care and for all staff in health and social care and the third sector, such as promoting



an information culture, communicating effectively with older people and their carers, empowering families, carers and others to support individuals with dementia, communication and understanding the need to support and work with family and friends of the individual.

Tsaroucha et al. (2010) developed the “West Midlands Competencies Framework for Dementia Workers”. The framework includes core competencies around knowledge and awareness of dementia related issues, person-centred care, interaction with patients, interaction with families, understanding challenging behaviour, and promoting best practice. The framework was designed to be suitable for the entire dementia workforce in the West Midlands. The projects aims were twofold: To develop a core competency framework and to conduct a mapping exercise in order to plot the developed competencies and skills against the Dementia Care Pathway. The competencies were developed based on a staged methodology. In the first stage, they carried out a systematic literature review; this identified 18 frameworks, 5 of which have been included in this review. The others did not appear relevant as they were either too local, or not well developed enough.

The West Midlands framework was also developed using the findings from interviews with training providers, users and carers and expert groups. The identified competencies were then placed in a hierarchy of relevance to dementia. According to Tsaroucha et al. (2010) dementia specific competencies were placed at the top of the hierarchy with the first being “knowledge/awareness of dementia and dementia related issues”, followed by competencies such as “understanding the behaviours of individuals with dementia” or “enriching the life of individuals with dementia and

their carers” (p15). Competencies that were suitable for the dementia workforce but could also be applicable to other professionals, therefore non-dementia specific, such as “person-centred care”, “staff development and self care” or “promoting best practice” were placed at the lower end (Tsaroucha et al 2010). The skills within each competency were then divided into categories, which were adopted from Bloom’s (1956) taxonomy of learning domains: knowledge, technical skills and attitude/behavioural skills.

Next the identified skills were mapped against the Dementia Care Pathway (Sadd, 2008). A mapping template was designed, where the competencies and skills were placed on a vertical axis whilst the pathway was placed horizontally. Each one of the competencies was rated against each stage of the pathway stating a level of importance (Tsaroucha, et al. 2010). A Delphi study was designed to assist with the mapping exercise. The Delphi technique has been described as “a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole to deal with a complex problem” (Akins, Tolson and Cole, 2005) Copies were distributed to 200 experts. However the response was very poor (n=14), which may undermine the reliability of the mapping exercise. Tsaroucha et al (2010) state this may have been due to its complexity. The authors state that although training is not usually related to competencies, it would be possible to relate curriculum to competencies which may be a useful mechanism for “looking to develop the dementia workforce” (p 64). The framework was developed specifically for the West Midlands so the project findings may not be generalisable to other care settings.

Adams (2008) developed a competencies framework for dementia care nursing based on the Ten Shared Capabilities, the Knowledge and Skills framework (KSF), National Occupational Standards and National workforce competencies, and the standards of proficiency for pre-registration nursing education to achieve the NMC standards of proficiency (standard 7) (NMC). This included 7 competencies including promoting a culture of values and respect for the diversity of people with dementia and their families, improving outcomes for service users, multidisciplinary and multi-agency working. The skills and theory associated with each competency are identified within the framework.

Traynor and Dewing (2002) developed a competency framework for admiral nurses. Admiral Nurses are “specialist dementia care nurses” (p1). Their work focuses primarily on the needs of carers and supporters of people with a dementia. They have an educative and consultative role which according to the Traynor and Dewing (2002) aims to improve the delivery and access to dementia services. The Admiral Nurses actively participated in the project and the development of the competency framework structure. Other stakeholders’ views about the Admiral Nurse Service were also sought and utilised. An Advisory Group, made up of representatives from various areas, also reviewed the work from the beginning of the project. The competency framework is made up of a set of ‘outcomes based’ competency statements; this is in line with the NMC’s approach to describing nursing practice (Traynor and Dewing, 2002). According to the Traynor and Dewing (2002) the evidence was drawn from a wide range of sources ensuring all aspects of the work undertaken by admiral nurses was captured. The framework is structured around eight core competencies including therapeutic work, sharing information about dementia and carer issues, advanced

assessment skills, prioritising work, preventative work and health promotion, ethical and person-centred care, balancing the needs of the carer and the person with dementia and finally promoting best practice

De Vries, Brooker and Porter (2010) developed competencies and models for role development and training for a “Primary care Liaison Worker” who would support the diagnosis and pre-diagnosis of dementia. Sadd et al (2008) defined this role as enabling a person with suspected dementia to access an assessment process directly and with appropriately. Draft competencies were developed based on the literature and policy documents, including existing job descriptions for similar roles. The draft competencies were then distributed to stakeholders via a consultation process which included a focus group. De Vries, Brooker and Porter (2010) state that the competencies were validated by the stakeholders, however it is not clear in the report how this process was undertaken. Competencies include knowledge/awareness of dementia and dementia related issues, which includes having sound academic and up-to-date research and clinical knowledge of a “path physiology of dementia” (p21); a comprehensive understanding of the behaviours of individuals with early cognitive impairment, including an advanced awareness of the impact of the fear and stigma associated with a diagnosis of dementia and of potential losses associated with a diagnosis of dementia; skills in interacting with people with a wide range of illnesses including mild cognitive impairment; competencies in providing education/facilitation and giving information to families and caregivers; skills in pre-diagnostic screening and personal qualities such as empathy, warmth and genuineness.

Tsaroucha et al. (2010) also developed an additional framework and job description for a “Dementia pathway co-ordinator” (DPC). The competencies framework for this new role was based on a literature search and consultations with stakeholders including professionals and people with dementia and their carers. This role was developed in parallel with the project conducted by De Vries, Brooker and Porter (2010). The role of the DPC was identified by the Dementia clinical pathway group report (Saad et al. 2008). The DPC would support the person with dementia after they have received their diagnosis and earlier support from the primary care liaison worker. Tsaroucha et al (2010) reported that stakeholders regarded a number of competencies as critical including sensitivity, a caring attitude and consistency. A total of 8 core competencies were identified including knowledge and awareness of dementia, understanding behaviours, enhancing the life of people with dementia and their carers, interaction with both individuals with dementia and carers, personal development, person-centred care and promoting best practice.

### Summary

This review includes frameworks developed using a range of different methods including questionnaires and interviews, Delphi panels, systematic literature reviews, analysis of job specifications and consultations with stakeholders including both experts and caregivers. A number of frameworks were identified. At one extreme, these include generic competency frameworks which have been developed for staff working across social, health and third sector services including “Skills for Care” (2005) and the “West Midlands Competencies Framework for Dementia Workers” (2010). By contrast, at the other end of the spectrum, the frameworks developed by Vries et al. (2010), Tsaroucha et al. (2010) and the Traynor and Dewing (2002) adopt a

micro view and focus on new and extremely specialised roles. The frameworks discussed in this review do not however identify the overarching competencies required for the broader specialist mental health service workforce.

Universal themes are evident in the frameworks which were reviewed, including the need for competence in person-centred care, knowledge and awareness of dementia and managing perceived challenging behaviour. Many of these common competencies will be relevant to the framework I was asked to develop. The rationale for this study therefore is that, although the literature review demonstrates that standards for professions such as physiotherapy and occupational therapy differentiate between generic and specialist competencies, similar sets of standards have not been generated for nursing except in the case of specialist roles such as admiral nurses (RCN, 2002). Neither is there a competency framework which has been developed for staff across a range of different disciplines working in a specialist dementia care setting. It was therefore appropriate to fill this gap, in line with Trust aims, to try and establish the areas and levels of competence required of the specialist dementia workforce, and in the light of the information gathered to integrate this as appropriate with pre-existing frameworks.

### Methodology

In order to develop the framework it was necessary to develop an in-depth understanding of the roles within the service. Several different data collection methods were used in order to achieve this. These included semi-structured interviews with key clinical leads, followed by a brief survey and focus groups with a wider sample of staff. Content analysis of the responses was then used to produce the

framework, integrating the findings with those of previous frameworks. Please see appendix 12 for Gant chart outlining overall work plan for the project.

### Ethical Issues

The project was viewed as a service evaluation by the Trust's Research and Development (R&D) Department. However ethical principles were adhered to and full informed consent was obtained from all of the staff who participated in the study. All data collected was anonymised and stored in the Trust's R&D department therefore participants were fully protected from deception or harm.

### Data Collection

#### Interviews with Key clinical Leads:

Interviews were undertaken with key clinical leads from a range of disciplines within the Trust's Mental Health Services for Older People (MHSOP) division. These clinical leads were identified as carrying the "vision" for the Trust's new service model. The purpose of these consultations was to gain a picture of the roles and activities undertaken by staff working within MHSOP, from the perspective of those with the greatest strategic influence. The interviews also explored staff's training needs and the key skills which they consider staff require in order to provide high quality dementia care. (See Appendix 2 for interview schedule).

The sample could be described as "purposive" in that respondents were deliberately chosen because of their level of expertise and knowledge. According to Bowling (2005) choices concerning sampling strategies should at the very least be made transparent and explicit. A total of 30 interviews were undertaken in a variety of

settings including, Community Mental Health Teams (CMHTs) (n=5), inpatient services (n=17), Psychology (n=3), Community Enable Recovery Team (CERTS) (n=1), Memory Assessment Services (n=2) and Working Age Dementia Services (WADS) (n=2). Participants came from a range of professional backgrounds including medicine, psychology, nursing, physiotherapy and occupational therapy.

The interviews were semi-structured and lasted approximately one hour. According to Morse and Field (1996) this method of data collection can be used when the researcher knows most of the questions to ask but cannot predict the answer. The interviews were not recorded; however comprehensive hand written notes were made. (Please see Appendix 3 for an example of handwritten notes. The interviews were not recorded, as this was primarily a scoping exercise to determine the following project activities, however comprehensive hand written notes were made. (Please see Appendix 3 for an example of handwritten notes).

#### Staff Survey:

Following the interviews with key clinical leads, the information was supplemented by a semi-structured questionnaire. This was sent electronically to a total of 40 clinical leads and managers from a range of disciplines across the service who were asked to circulate the survey to their teams. As these individuals circulated the survey at their discretion therefore it was not possible to determine the response rate.

The sample can therefore be described as convenience (Bowling, 2005). Participants who completed the survey were at varying levels within the organisation, but were all professionally qualified.



The three questions for the survey were informed by the interviews with the key clinical leads as there was a need to distinguish between generic and specialist competencies. It consisted of 3 open-ended questions:

- 1) Identify 3 specialist competencies
- 2) Identify 3 generic competencies
- 3) Describe how your practice is different from working with people who do not have dementia.

The data collection tool was piloted before use in order to ensure it was understandable and simple to complete. According to Holloway and Wheeler (1996) semi-structured questionnaires are useful because they ensure that the researcher obtains all the information needed, while at the same time allowing the participant freedom to respond. It also enables the researcher to collect similar types of data from all the respondents, and this saves the researcher time (Bowling, 2005).

Completed questionnaires were returned anonymously by participants using a stamped addressed envelope. A total of 26 responses were collected from staff from a range of disciplines including medicine, psychology, nursing, physiotherapy and occupational therapy. (See appendix 4 for staff survey).

#### Focus groups:

In addition to the interviews and the survey, focus groups were also carried out with a wider range of staff, including unqualified staff. These were primarily conducted to explore the best ways of delivering training, rather than to explore competencies per

se. However, a large amount of material emerged during the focus groups regarding the competencies perceived as essential to work with people with dementia. This material was included in the development of the competency framework and is integrated into the final framework shown below. Where competencies were echoed in the focus group content as well as in the interviews, questionnaire data or pre-existing frameworks, this is indicated in the framework. The focus groups are the subject of the next chapter and their participants and conduct are described in detail in that chapter.

### Analysis

Content analysis was used as the first stage of the thematic analysis for the data arising from the interviews with clinical leads and the text of the survey responses. The researcher initially read her detailed notes of the interviews and the text of the survey to gain an overall impression. The material was then coded by topic, and the topics were expanded, refined, or altered to become the primary categories, through a process of constant comparison (Glaser and Strauss, 1967).

According to Morse and Field (2002) content analysis is analysis by topic. These topics become primary categories or category labels. Content analysis initially aims for data reduction by taking a large volume of material and attempting to identify case consistencies and meanings, which can be described as “inductive” (Patton, 2002). According to Weber (1990) content analysis is misunderstood and a common preconception is that words and phrases mentioned are simply counted. According to Donavan and Sanders (2005) content analysis, used in first stage of analysis becomes

more akin to “constant comparison/thematic approaches” although if it is undertaken in its own right can produce superficial findings. Content analysis as the simplest method for analysing qualitative data as it is the first stage of developing thematic frameworks and requires the “identification of codes to begin the early categorisation of data” (Donavan and Sanders, 2005 p. 521). An approach known as “emergent coding” was used and the steps outlined by Haney et al. (1998) were adopted as following initial examination of the data, the material was then reviewed and a checklist formed. This checklist was used to apply further coding. Slight differences in words were collapsed into single categories. The competencies thus identified were compared and matched to arrive at a single merged list.

### Trustworthiness

A number of steps were taken to ensure the trustworthiness of the data. Another colleague who is a senior lecturer at a large local university was involved in developing the themes. In addition the emerging framework was discussed with other experts in the field.

### Framework development

The competencies identified from the interviews, the staff survey and the focus groups were then integrated with pertinent competencies from pre-existing frameworks. The existing frameworks identified in the literature were reviewed and the competencies and skills that applied to dementia care were adopted and or/adapted accordingly. A similar method of competency development is described by Tsaroucha et al (2010) and De Vries (2010). Michie et al. (2011) states that this ensures that one identifies

those competencies for which there is a degree of consensus, evidential support and a level of accord in the literature.

## Results

### Interviews:

Six main themes were identified from the interviews with senior staff, each with a number of related sub-themes (see Table 2).

Table 2. Consultations with key clinical leads

<b>1. Knowledge and Awareness of Dementia Issues:</b>  <b>The consultations demonstrated that staff should all have a basic understanding dementia and how it affects people and also an understanding of behaviours of people living with dementia. There were 7 distinct themes;</b>
Understanding of dementia signs and symptoms
Understanding the impact of behaviour
Safeguarding vulnerable adults
Dual/Differential diagnosis
Understanding neuropsychological deficits
De-escalation techniques
Observation skills

<b>2.Maintaining Levels of Functioning:</b>  <b>The consultations demonstrated that maintaining the independence and functional status of people with dementia was seen as a key skill along with</b>
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<b>facilitating access to occupation and participation. There were 4 themes;</b>
Promoting independence
Promoting cognitive function
Maximising independent activity and enhancing level of functioning
Engagement with local communities
Maximisation of independence, choice and well-being

<b>3.Therapeutic Approaches:</b>  <b>The consultations demonstrated that staff should have the skills in order to work therapeutically with older people selecting and delivering interventions as appropriate. 4 main sub-themes were identified;</b>
Skills in dementia focused interventions e.g. CBT,CST
Counselling skills
Skills in validation therapy, reminiscence, life story work
Supporting recovery

<b>4. Person-centred care:</b>  <b>This was identified as a basic core principle and fundamental when working with people with dementia and their families and consisted of 4 main themes;</b>
Understanding behaviour as a means of communication
Implementing a person-centred approach
Philosophy of Dementia care mapping

Communication skills
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<b>5. Interaction with carers and families:</b>
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<b>Consultancy was seen as a key skill and the ability to engage with families as equal partnerships in care in order to maintain to maintain the health, safety and well-being of people with dementia were identified as key skills. This consisted of 5 main themes;</b>
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Customer carer/ Dealing with difficult relatives
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Understanding carer's perspective, feelings of grief, coming to terms with progression of illness etc.
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Advisory/support role
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Liaison role/carer education
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Facilitating joint decision making
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<b>6. Personal and professional development;</b>
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<b>Demonstrating skills for professional development and personal supervision activities was seen as key with 9 main themes;</b>
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Managing work related pressures stress/burnout
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Developing of skills for reflective practice/self awareness
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Skills in supervision/mentorship
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Awareness of negative ward cultures
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Effective team work
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Respecting others roles/disciplines
Strong leadership/management skills
Sharing good practice
Prioritising own work load

#### **7. Ethical/Legal Issues:**

**The consultations demonstrated that staff should have knowledge of the mental capacity act and be able to create environments which facilitate ethical decision making. 3 main themes were identified;**

Knowledge of Mental Capacity Act

Supporting and assessing capacity

Knowledge of ethical principles

#### **8. Physical Care:**

**Skills focusing on physical care were identified with 4 main themes;**

Management of physical health

Nutritional needs

Recognition of signs of physical ill-being

Assessment of physical health

**9. Assessment:**

**Assessment skills were viewed as key with four main themes;**

Understanding assessment tools

Understanding/skills in neuropsychological assessment

Assessment and care planning for individual needs

Staff Survey:

The responses to question 1 and 2 of the survey identifying specialist and generic competencies were tabulated as defined by the participants (See Table 3). Question 3 as judged as not yielding extra information. A total of 16 different generic and specialist competencies were identified.

Table 3. Staff Survey

<b>Generic Competencies</b>	<b>Specialist Competencies</b>
Knowledge of dementia pathology	Medication management
Understanding of the illness	Counselling skills
Person-centred care and the ability to apply the model in practice	In depth knowledge of dementia pathology
Communication skills	An in-depth knowledge base
Observation skills	Diagnostic skills
Flexibility in ways of working	Falls awareness/Manual handling
Manual handling skills	Understanding of concomitant mental



	health problems e.g. depression
Recognition of emotional impact of dementia	Evidenced based cognitive therapies e.g. Cognitive Behaviour therapy
Ability to identify age related changes vs. cognitive changes	Management of behavioural and psychological symptoms of dementia
Approach e.g. “patience” “understanding” and “compassion”	Understanding occupation as a method of assessment
Understanding the main symptoms of dementia	Activity analysis and graded activity
Understanding dementia classifications or “types”	Observation and interpretation of behaviour
Recognising dementia symptoms	Ability to explain condition and it’s impact on the day to day life of service user and family
Knowledge of service provision and ability to signpost	Engagement in meaningful activity And understanding how to engage with people with severe dementia
Understanding of capacity	Working knowledge of bio-psychosocial influences on challenging behaviour
Knowledge of Mental Capacity Act and able to complete capacity assessment	Understanding dementia and depression can present in a similar way-ability to differentiate and recognise

### Development of an integrated framework

A number of different themes emerged from the interviews and staff survey. The findings from the staff survey provided data concerning which competencies were perceived to be generic or specialist whereas the findings from the interviews provided an overview of the roles and activities undertaken by staff within the service. Through comparing and contrasting the outcomes of the interviews, the survey and pre-existing relevant frameworks (as well as the focus group material where appropriate). A total of 129 competencies were identified in all. The source for each is identified in the framework (see Table 4 for competency framework).

The 129 competencies were divided into a total of 8 clusters: skills for working effectively with people with dementia and their families; advanced assessment skills; understanding of the behaviours of people with dementia; enhancing the psychological well-being of people with dementia, skills in clinical leadership, skills in personal and professional development, skills in promoting the physical well-being of people living with dementia and finally understanding of the ethical and legal issues in relation to people living with dementia. This process utilised some of the steps for systematic categorisation as described by Patton (1987), Guba (1978) and Cook (2003): “Firstly judging the extent to which categories fit together (homogeneity), and making connections (surfacing), secondly checking the differences were bold and clear, and thirdly proposing new information that ought to fit and then verifying its existence” (Cook 2003 p, 22).

Each item in the list of individual competencies was then classified as Generic, Specialist or Advanced. Generic competencies were defined as the competencies which all staff require who are working with people with dementia, including those

staff who are working in a wide range of settings including residential and nursing homes. Specialist competencies were described as those competencies necessary for staff of all disciplines working within a specialist mental health service. Some of these may be acquired through professional training. Advanced denotes competencies which seem to be complex enough to require further higher professional training, (Hamric, 2005), rather than being possible to acquire through a specific continuing professional development course, because they involve acquiring and understanding a body of underlying knowledge rather than the learning of specific disaggregated skills e.g. psychological formulations, assessment and diagnosis.

Next each competency was critically appraised by the research team and separated into levels. Steinaker and Bell's Experiential Taxonomy (1979) was adopted in order to carry out this process. A number of educational taxonomies were considered for this purpose including Bloom's (1956), however Steinaker and Bell's appeared to be the most appropriate as it is frequently used in curriculum development. The Irish Nursing Board (2001) adapted and applied the Steinaker and Bell taxonomy to the development of nursing competence among students. The goal was to describe both the general performance expectations for students and the focus for assessment and evaluation. Each area of competence was considered in turn in a meeting consisting of a senior lecturer from a local university, a clinical psychologist and myself. Where there was disagreement, the allocation was debated until consensus was achieved. There was however immediate consensus for most of the competencies.

According to Eraut (1994), the taxonomy includes level 1, exposure (discovery); level 2, identification (participation); level 3, internalisation (demonstrating the ability to

use problem solving skills, critical analysis and evaluation); level 4, participation (drawing conclusions, finding connections and making comparisons to other situations); and level 5, dissemination (advising others, teaching junior colleagues, identifying personal management styles and managing care delivery by junior staff).

Several fundamental or generic competencies were shared across all 5 of these levels as it was recognised that every one working with older people with dementia requires these skills e.g. an understanding of dementia, knowledge of person-centred approach. Specialist competencies were identified as level 4 of the taxonomy and advanced as level 5.

The competencies can also be classified in terms of focus on skills versus knowledge and their function in supporting change in practice (Michie, 2011). The rationale for dividing competencies in this way was that skills and knowledge typically require different modes of assessment and training (Michie, 2011). For example it may be possible to teach competencies identified as knowledge based using techniques such as e-learning whereas attitudinal and skills based competencies may require more experiential methods. Therefore in the competency framework in table 4, the competencies are written in such a way as to make clear if they refer to knowledge or to skills.

Table 4.Competency framework for clinical staff working in specialist dementia services

Competencies	Source	Level
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FG=Focus Group, LR=Literature Review, SS=Staff survey, INT=Interview, \*=all 4 sources

Cluster 1) Skills for Working effectively with people with Dementia and their families

Demonstrate an <i>understanding of dementia</i>	FG,LR,SS, INT*	1-5
Understand the principles and values of <i>person-centred care</i> and ability to apply in practice	SS,FG,LR, INT*	1-5
Demonstrate a <i>Person-centred Approach</i> and an understanding of how to work with people with moderate to severe dementia e.g. patience, respect, understanding, compassion, empathy. (Knowing the person, Seeing the Person)	SS,FG,INT, LR*	1-5
Demonstrate an awareness of <i>approaches aimed at improving quality of care</i> e.g. dementia care mapping	INT,LR	5
Demonstrate the ability to work <i>holistically and</i> flexibly, <i>adapting skills</i> according to the individuals and families needs	SS,FG,LR, INT*	1-5
Understand <i>the impact of dementia</i> on individuals in terms of	FG,SS,LR	1-5

emotions, needs, relationships and practical issues	INT*	
Understand the <i>impact of dementia</i> on individual's families	SS,FG,LR INT*	1-5
Knowledge on how to involve <i>individuals and families in their own care planning</i>	LR,FG,INT	4
Knowledge of the health and social policy and planning issues related to Dementia and an understanding of care pathways	LR	4-5
Understand <i>relevant dementia models of dementia care</i> e.g. Brooker's VIPs model and Sheard's BEING approach and identify strengths and weakness	LR	4-5
To be able to work within and have knowledge of the <i>Recovery/Enablement model</i> . Empowering individuals with dementia and their families. Promoting inclusive decision making, enabling people with dementia to make informed choices	INT,SS,LR FG*	4-5
Demonstrate <i>sensitivity to diversity</i> relating to age spirituality, religion and disability promoting an all inclusive culture	INT,FG,LR	1-5
Demonstrate <i>effective communication skills</i> (non-verbal/verbal) and the ability to identify strategies which can be used to overcome cognitive and sensory impairments	SS,INT,FG LR*	1-5
To be able to undertake an advisory role, liaising <i>effectively with individual's carers</i> , families and other professionals	SS,FG,INT, LR*	4-5

Recognise and manage risk appropriately and undertake comprehensive risk assessment. Work with individuals and their carers and families to promote independence and social inclusion while managing risk	SS,FG,LR, INT*	4
Understand and demonstrate an awareness of the factors associated with <i>safeguarding vulnerable adults</i>	SS,INT,LR	1-5
To be able to provide <i>effective support and education</i> to individuals and carers	SS,FG,LR INT*	4-5
To be able advice on <i>future direction of care</i> for individuals and their families	SS,INT,FG	4-5
<i>Knowledge of local service provision</i> , care pathways and ability to signpost for further assessment ensuring fair access to specialist and non-specialist services determined by need. (Including third sector services)	LR,FG,SS FG*	4-5
Knowledge of <i>medication used for the management</i> of dementia including anti-dementia medications	SS,LR,INT, FG*	4-5

Cluster 2) Advanced assessment Skills:

Demonstrate <i>advanced assessment and diagnostic</i> skills	SS,INT	5
To understand the <i>psychological consequences of cerebral and physical disease</i>	INT	5
Demonstrate an understanding of the <i>psychological and</i>	SS,LR	4-5

<i>emotional impact of diagnosis</i> on the individual and their family		
Demonstrate an awareness of the <i>common types of dementia</i> and how the illness presents	SS,FG,INT, LR*	1-5
Demonstrate an in depth knowledge of the <i>causes of dementia</i> and pathophysiology underpinning the most common types of dementia	SS,INT,FG LR*	4-5
In depth understanding and recognition of the <i>signs and symptoms</i> of dementia	SS,FG,INT, LR*	4-5
Demonstrate an understanding of <i>the progression and variable nature of the illness</i>	SS,FG,INT LR*	4-5
Be able to explain and demonstrate skills in <i>neuropsychological assessment</i> and be able to select and administer evidenced based psychometric assessment tools/scales e.g. MMSE, BADLS, CAMCOG, and interpret outcomes	SS,INT	5
To be able to select and administer <i>Quality of Life measures</i>	INT	5
Have a <i>cultural specific understanding</i> of ethnicity and how it affects presentation. Be able to interpret and understand how culture and ethnicity can impinge on assessments	INT	5
Demonstrate advanced <i>observational</i> skills to gather information in order to interpret behaviour	SS,INT ,FG	1-5
To be able to successfully <i>communicate results of diagnosis</i>	SS,LR	5



and its impact to individuals and their families		
Able to organise <i>appropriate follow up following</i> diagnosis	SS	5
Ensure people living with Dementia and their families are <i>included in the assessment process and decision-making</i> following the diagnosis	SS,LR	4-5
<i>Knowledge of the pre-diagnostic experiences</i> of dementia and appropriate use of pre-diagnostic assessments	LR	4-5
To have <i>knowledge of MCI and dementia and to distinguish between dementia, age related changes, delirium and other mental health problems including depression</i> and to understand the relationship between depression and dementia	SS,INT	4-5
Demonstrate an understanding of <i>dual diagnosis</i> e.g. dementia and depression, dementia and learning disabilities	FG,INT,LR INT*	4-5
Be able to undertake or <i>arrange further investigations</i> as appropriate	INT	5
Able to <i>interpret physical investigations</i> e.g. neuro-imaging	INT	5
Specialist evidenced based knowledge of a range <i>pharmacological treatments</i> for a range of dementia conditions relating to prevailing NHS guidelines	INT	5
Be able to <i>assess a situation, determine the severity and nature of the problem</i> and refer to an appropriate person	FG	4-5
Ability to assess level of <i>risk</i> and consider how the risk can be	FG	4-5

managed		
Demonstrate <i>advanced counselling skills</i> when supporting an individual and their families during or following diagnosis	FG,LR	4-5
Ability to assess factors associated with self-harm, self <i>neglect, suicide and risk of harm</i> from others	LR	4-5

Cluster 3. Understanding of the Behaviours of People with Dementia:

Identify the <i>behavioural consequences</i> that may present throughout the course of the illness	LR,INT,FG SS*	4-5
Ability to <i>recognise the needs</i> of people with dementia, maximising strengths and minimising weakness	FG,LR	1-5
Develop and implement skills in <i>problem solving, and</i> recognition of behaviour changes	FG,LR	1-5
Recognition of <i>triggers for Behavioural and Psychological symptoms</i> of dementia (BPSD) e.g. unmet need	SS,FG,LR, INT*	1-5
Undertake <i>appropriate behavioural analysis and assessment</i> of need using methods such as ABC.	FG	4-5
Knowledge of <i>anger management and de-escalation</i> techniques	LR,INT	1-5
Ability to manage <i>expressions of distress</i>	LR	1-5

Develop strategies to ensure the person's life history and <i>individual preferences</i> are taken into account	FG	1-5
Demonstrate working Knowledge of the bio-psychosocial influences on behaviour and use of corresponding evidenced based <i>management strategies</i> such as environmental modifications, behavioural and psychological interventions	SS	4-5
Have evidenced based knowledge of pharmacological treatments of behavioural disturbance	INT	5
Deliver all <i>activities of daily living e.g. personal care, feeding</i> using a person-centred approach e.g. offering choice, making connections, demonstrating empathy and respectfulness	FG	1-5
Demonstrate awareness of the <i>impact of physical, social and environmental</i> factors on the individual	FG,LR,INT	1-5
Promote <i>safety of individuals</i> and staff members and contribute to the safe and effective management and reduction of risk e.g. through medication, counselling etc.	FG,LR	1-5

#### Cluster 4) Enhance the psychological well-being of people with Dementia

Demonstrate the ability to develop an establish and maintain an <i>effective therapeutic relationship</i> and rapport with people living with dementia and their families	SS,FG,LR, INT*	1-5
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Ability to gain <i>trust and cooperation</i> of people living with dementia and their families	FG	1-5
To be able to offer <i>effective support</i> and use of <i>basic counselling</i> to people with dementia and their families	SS	1-5
To be able to offer effective support and interventions for <i>concomitant mental health problems</i> e.g. depression	SS	4-5
To be able to determine <i>psychological formulations</i>	INT	5
To be able to deliver evidenced <i>dementia focused interventions</i> e.g. validation therapy, reminiscence, life review, Cognitive stimulation (CST), Cognitive Behaviour Therapy (CBT), Reading for Well-Being	SS,INT	4-5
Facilitate <i>engagement</i> with local communities	INT	1-5
Promote positive views of people living with dementia by <i>valuing experiences</i> and life stories	FG	1-5
Able to work with families to develop appropriate activities	LR	1-5
Identify strategies to <i>maintain individual's level of functioning</i> , cognition, skills and health at optimum level, supporting individuals to retain and develop skills	INT,SS,LR, FG*	1-5
Be able to engage individuals in <i>meaningful occupational activity</i> , <i>facilitate groups and 1:1 activity</i> which take into account the person's preferences and choice	SS	1-5
Undertake <i>activity analysis and, graded activity and</i>	SS	4-5

<i>adaptation</i>		
Understanding <i>occupation and activity</i> as a method of assessment	SS	4-5
Think <i>creatively and innovatively</i> about <i>the provision of activities</i> , promoting positive meaningful social interactions and see activity in the widest possible sense	SS,INT	4-5
Take account of <i>individuals capabilities and limitations</i> , their wishes and personal history when planning or providing occupational activity	FG,INT	1-5
Demonstrate ability to <i>connect with people</i> who are cognitively impaired with reduced attention spans and maximise brief positive interactions .e.g. creating a 30 second activity	FG,LR	1-5
Demonstrate an understanding of <i>models of providing activity</i> for people with memory problems e.g. Sheard's Butterfly approach (2009)	LR	4-5

#### Cluster 5. Demonstrate skills in Clinical Leadership

Demonstrate a <i>high level knowledge of research evidence</i> in relation to dementia and dementia care	LR	5
Demonstrate ability to <i>transfer and adapt own skills</i> to a variety of settings	FG	4-5
Demonstrate effective <i>role modelling</i> for other colleagues	FG	1-5

The ability to recognise negative ward cultures and to undertake <i>effective change management</i> when necessary	INT	1-5
Demonstrate <i>advanced skills in research and evaluation</i> . Ability to undertake research projects/service evaluations/audits	LR	5
Be able to identify <i>evidenced based practice</i> (EBP) and promote EBP, keeping knowledge and skills up to date	LR	4-5
<i>Awareness of health and dementia policies and legislation</i> and how these will determine current service provision and direct patient care	LR	4-5
Demonstrate the ability to <i>motivate</i> colleagues. Promote <i>best practice and the sharing of innovation</i> through effective leadership and consultancy	SS,INT	1-5
Demonstrate <i>effective leadership skills</i> working effectively and assertively in a team, contributing to the decision making process and taking responsibility for associated actions	INT	1-5
Support the <i>education, teaching and learning</i> for other staff members	FG	1-5
Demonstrate a <i>multi-disciplinary perspective and promote multi-disciplinary working</i> , working effectively across professional boundaries, understanding and respecting each professional group	INT	4-5
Demonstrate <i>effective skills in liaison and negotiation</i> with	LR	4-5

other services/teams		
Delegate care and other tasks <i>effectively and manage competing demands</i> . Be able to plan/prioritise work according to needs of service and undertake effective time management	LR	4-5
To be able to <i>confidentially deliver group presentations/seminars</i>	LR	4-5
To be able to <i>deliver information</i> to the individual, family members, and a wide range of professionals	FG	4-5

Cluster 6. Demonstrate skills in Personal and Professional Development

Be able to clarify and confirm own <i>professional role</i> and demonstrate <i>professional confidence</i>	FG	4-5
To be able to identify <i>specialist skills</i> associated with role	FG	4-5
To have <i>confidence in one's own clinical abilities</i> and be assertive. Having a sense of self worth, self-esteem and connection	FG,LR	1-5
Be able to demonstrate effective skills in <i>clinical supervision and mentorship</i>	FG,LR	4-5
Undertake <i>reflective practice</i> and recognition of emotional labour to facilitate ongoing insights into emotional state and its impact on care practices	FG,LR	1-5
To recognise the need for appropriate or additional support in the work place and be able to identify means of accessing this	LR,FG	1-5

To be able to manage grief and loss appropriately	LR	1-5
Offer timely and effective <i>support for colleagues</i> working within own team enabling other colleagues to reflect on their own practice	FG,LR	1-5
Be able to practice <i>autonomously</i> and exercise own judgement	FG,LR	1-5
Demonstrate effective <i>coping skills/stress management</i> , resilience and emotional competence	INT,FG,LR	4-5
Manage <i>personal and professional development</i> . Identify <i>gaps in knowledge</i> and seek appropriate education/learning	FG,LR	1-5
Be able to set realistic achievable <i>professional goals</i>	LR	4-5
Work effectively within a team <i>valuing and supporting other team members</i> and colleagues contributions	FG,LR	1-5

#### Cluster 7. Enhance physical-well-being of people living with Dementia

Demonstrate an understanding of all <i>aspects of physical well-being</i>	LR	1-5
To be able to undertake <i>assessments of physical well-being</i>	SS,FG	4-5
Ability to adapt the physical environment to <i>maximise the individuals level of functioning</i>	FG,LR	4-5
Demonstrate an in depth understanding of pharmacology and pharmacovigilance ( <i>Medication Management</i> )	SS,INT,FG	4-5
Be able to deliver effective <i>end of life/palliative care</i> and support individuals and their families through the end of life	SS,FG,LR	1-5



process		
Demonstrate skills in <i>wound care and tissue viability</i>	SS,FG	1-4
Demonstrate an <i>understanding of co-morbidity of physical and psychological problems</i>	LR	4-5
Understand <i>psychological impact on the person's physical health well-being</i>	FG	4-5
Demonstrate effective <i>Manual Handling Skills</i>	SS,FG	1-4
To deliver interventions to <i>improve physical well-being</i> e.g. music/environmental approaches, EXTEND	SS,FG	1-4
Be able to assess the risk of falls and deliver <i>falls prevention</i> . Interventions for fear of falling	SS,FG	1-4
Understanding of <i>anatomy and physiology</i>	SS,FG	4-5
Undertake effective <i>health promotion</i>	LR	1-5
<i>Manage continence/incontinence</i> effectively	FG	1-4
<i>Ability to recognise symptoms of physical ill-being</i> e.g. UTI's, Constipation, Drug Interactions	INT,FG,LR	1-5
Ensure individuals receive an adequate <i>nutritional/fluid intake</i> and undertake effective monitoring	INT,LR	1-4
Demonstrate awareness of <i>pain management</i> strategies	FG	1-5
Recognise <i>delirium</i> and undertake an appropriate course of action	LR	1-5
Deliver effective <i>sleep hygiene advice</i>	LR	1-5

Cluster 8. Demonstrate an understanding of the Ethical and Legal issues in relation to people living with dementia

Understand the appropriate legal and ethical <i>frameworks</i> and how they can be used to support practice	LR	4-5
Undertake the assessment of <i>capacity and obtain valid informed consent</i>	SS,INT	1-5
To have knowledge of Knowledge of <i>Mental Capacity Act, Living wills, Advanced Directives</i>	INT,FG	4-5
To be able to undertake discussions with individuals and carers agreeing <i>advanced care decisions</i> planning and review processes	LR	4-5
Demonstrate the ability to promote <i>transparent decision making</i> promoting capacity for the inclusion of people living with dementia and their families	SS,INT	1-5
Support <i>ethical decision making</i> in relation care practices and act as an advocate for people with dementia and their families	LR	1-5
Discuss <i>ethical, legal and duty of care issues</i> specific to people with dementia and their carers	LR	4-5

Conclusion

The development of the framework has a number of strengths including the triangulation of the competencies using a range of sources (interviews, questionnaires, literature and focus groups). The competency framework builds on pre-existing

frameworks which have been predominantly developed using systematic literature reviews and analysis of job specifications, rather than incorporating the direct opinion of staff delivering care. The competency framework developed has a number of distinctive features in comparison with the existing frameworks identified in the review. Although frameworks have been developed for specialist roles within mental health services for older people, compared to other frameworks, this proposed version takes a broader overview of the competencies required for all staff working in such services. A bottom-up approach was taken and staff were interviewed from across the services and from all disciplines. The framework expands on the detail of several domains identified in existing frameworks, in particular it adds competencies in the domains of assessment, understanding dementia and leadership. A bottom-up approach was taken and staff were interviewed from across the services and from all disciplines. The framework developed expands on the detail of several domains identified in existing frameworks, in particular competencies in the domains of assessment, understanding dementia and leadership. Limitations include the small number of staff surveys which were returned (n=26). Also it may have been desirable to record and transcribe the interviews verbatim rather than taking handwritten notes, however due to time constraints this was not possible. The chapter demonstrates it is possible to identify competencies for staff working in a specialist dementia service. 129 competencies were identified and these formed 8 clusters (see appendix 11 for cluster diagram). This framework will form the basis of the curriculum for the dementia training developed as an outcome of this project which will be discussed in chapter 4. The findings from these consultations also informed the following project activities including development of the focus group schedule.

### **Chapter 3**

#### **FOCUS GROUPS CONDUCTED WITHIN CLINICIANS**

##### **Introduction**

In the following chapter the focus groups are presented. First the chapter addresses the theoretical underpinning for the study, which is phenomenology, and discusses how this is applied. This is followed by an explanation of the method of data collection and analysis. Thematic analysis was used as a framework for this. Following this the study sample and the methods used to ensure trustworthiness are discussed. The chapter finishes by presenting the findings from the focus groups with staff followed by those conducted with carers.

The initial objective of this study was to develop a better understanding of the roles of staff working within a mental health service and the skills, attitudes and knowledge that staff require in order to deliver a high quality service. Thus the focus groups were set up with a view to developing the competencies framework and understanding the staff's roles and training needs in line with the project brief. However, as will be illustrated below, the findings emerging from the focus groups regarding experiences of training led to a broadening of focus on to issues concerning the delivery of training as well as the roles of staff

Caregivers (family members of people with dementia) were also interviewed in order to explore their expectations of staff working within the service. These interviews were undertaken as the findings provided an additional outside, giving a third party view perspective on the skills required by staff.

## Method

A review of the potential methodologies was undertaken in order to establish the most appropriate means of investigating the research question. It was decided that the theoretical foundation of the investigative approach should be based on a qualitative/naturalistic method. A quantitative/positivist approach would not have produced the depth of information sought. Thus phenomenological inquiry was employed in this study to explore the staff members' and caregivers' experiences.

## Phenomenology

According to Polit and Beck (2004, p.253) phenomenology assumes there is an essence or "an essential invariant structure" that can be understood. Phenomenology investigates subjective phenomena in the belief that critical truths about reality are grounded in people's lived experiences (Darroch and Silvers, 1982). Phenomenologists argue that lived experience gives meaning to each person's perception of a particular phenomenon. The goal of a phenomenological study is to fully and accurately describe the lived experience and the perceptions to which it gives rise, not to generate theories or models or to develop an explanation (Morse and Field, 1996).

## Data Collection

A total of 14 focus groups were conducted with staff with 70 participants in total. Two further focus groups were conducted with caregivers with a total of 16 participants. The number of participants in the focus groups ranged from 3-14 (mean=7) A large sample size and a large number of groups were required due to the service setting. The service consists of staff from a number of disciplines and grades

working across a range of different service settings, all of whom would bring different perspectives. Focus groups were conducted separately with staff from differing service settings e.g. community and inpatient wards. The participants included qualified and unqualified nursing staff from 2 continuing care wards, 2 community mental health teams and 2 assessment wards. Nursing staff from the same service setting but different grades were interviewed separately as existing power dynamics between respondents who work together may have inhibited discussions (Carter and Henderson, 2005). In addition Occupational Therapy staff were interviewed in two groups, separated by grade, and Physiotherapy staff were interviewed in one group. (Please see Appendix 7 for composition of focus groups). Staff from the same service setting but different grades were also interviewed separately as existing power dynamics between respondents who work together may have inhibited discussions (Carter and Henderson, 2005). I facilitated and led the focus groups and was accompanied by a senior lecturer from a local university, who had agreed to co-facilitate and who took a supportive role following up issues raised by using additional probes as appropriate. The interview schedule was developed to address the aims and objectives of the project with topic areas chosen to facilitate discussion of staff's perceptions of prior training, ideas about the type of training required and the competencies and skills required for staff working within a specialist mental health service. (See Appendix 5 for interview schedule).

Purposive sampling was used as staff were selected on the basis of being from a particular setting and discipline. Each focus group can be described as homogeneous as the staff shared the experience of working together on a particular ward or area. Similarly the caregivers shared the experience of having a family member being cared

for in a common setting within the organisation. The focus groups were audio-recorded, anonymised and transcribed verbatim.

The groups were conducted in participants' clinical areas. Staff volunteered to take part and an invitation letter and participant information sheet was sent to participants prior to their participation. (See appendix 8 for Participant Information sheets and consent forms). Staff were assured all the information would be anonymised and full informed consent was taken.

### Analysis

Due to the large sample size and a need to draw from perspectives across a range of disciplines and service settings thematic analysis (Braun and Clarke, 2006) was felt to be the most appropriate for understanding the training needs and training delivery from perspectives of staff within the service. It was decided to base the analysis on Willig's (2001) summary of the IPA (Interpretative Phenomenological Analysis) process in order to produce a thorough account from a systematic consideration of the data. The steps outlined by Willig (2001) were undertaken: The first stage of IPA involves reading and re-reading the text. The second stage requires the researcher "to identify and label themes that characterize each section of the text" (p. 58). The third stage involves identifying clusters of themes and giving them descriptive labels.

Quotations from participants such as "ways of learning" or "feeling misunderstood" were used as labels. The fourth stage of analysis involved the construction of a summary table of the structured themes, together with illustrations of each theme. Some themes may be excluded during this phase if they do not appear regularly in the text or are not representative of the participants' experiences. Having produced a

summary table for each focus group an inclusive list of master themes was then generated to reflect the experiences of the group of participants as a whole. Larkin et al. (2006) argue the researcher must approach the data with the aim of trying to understand the participant's world and be aware of this in relation to a wider social context.

While I was interested in the phenomenology it was recognised that due to the need to draw out fairly general conclusions there was not an opportunity for a nuanced account of similarities and differences. Smith, Flowes and Larkin (2009) suggests that IPA pursues an idiographic commitment, exploring individual personal perspectives. Therefore the method of analysis drew on IPA but it cannot be considered a full application of that method.

### Trustworthiness

A number of different strategies were used in order to ensure the trustworthiness of the data. Member checks with 8 staff who participated in the focus groups in two different settings were undertaken. Each theme was discussed with in turn and some examples of extracts from the focus groups were also given. This process served to check the viability of the researcher's interpretation and is a technique which is used to ensure the accuracy, credibility and validity of the findings. If the participants affirm the accuracy and completeness, then the study is said to have credibility (Cormack, 1996). Member checks are not without fault, but serve to decrease the incidence of the implausible or mistaken interpretation of data. The overall goal of this process is to provide findings that are authentic and original (Tanaggard, 2008). The findings of the project were very well received and the participants agreed the



emergent themes captured their experiences. They were also very positive about the proposed recommendations. In addition for the purposes of credibility checking, two long standing clinicians with extensive experience of working with people with dementia and also of fostering staff development also reviewed the data and gave their opinion of emerging themes. These clinicians ensured plausibility and that the researcher remained grounded in the data. They provided consistent and at times challenging feedback on the analytic process. For example when generating and prioritizing themes and ensuring a joint understanding of these.

#### Researcher credibility/reflexivity

According to Whitehead (2004) the nature of qualitative analysis is at the heart of much controversy. This relates, in the main, to dependence on the analyst's insights and abilities, and also the ambiguity about the process of analysis (Pollock, 1991). According to Whitehead (2004) phenomenology recognises the influence of the researcher on the conduct and presentation of the study. Reflexivity means sensitivity to the ways in which the researcher and the research process have shaped the data collection, including the role of prior assumptions and experience, which can influence even the analysis (Mays and Pope, 2000). The researcher's reflexivity was crucial during the process of analysis. The researcher therefore considered the effects of her experience and background throughout this process. According to Marcus (1994) reflexivity involves the researcher intimately interacting with texts to make some sense of their meaning. A reflexive researcher is "aware of the ways in which self affects both the research processes and outcomes, and rigorously conveys to readers of research accounts how this happens." (p55). (See Appendix 9 for a summary of author's CV). The researcher's self awareness was raised by keeping a

reflective journal in which she recorded reflections on interactions and experiences with respondents. (An extract from the reflective journal is included in Appendix 10). Whitehead (2004) suggests that the reflective diary can act as a record of events and also be used to record how the researcher's horizon developed, providing material for reflection.

## Results

### Focus groups with staff

Five themes emerged from the focus groups with staff including competency based skills, beliefs, enablers, barriers and ways of learning. Each of these will be discussed in turn.

### Competency based skills

#### a) Defining specialist skills

At times all the participants struggled to define the skills necessary in the provision and delivery of high quality dementia care. This is demonstrated in the following extract:

*“Sometimes when you work with a specific group, you take your skills for granted don't you? It's kind of natural, it's like second nature and then when someone says what do you do, it's seems so natural, it's hard to exactly explain what you do”* (Occupational Therapist, FG 9).

When discussing specialist skills the focus group participants described being able to draw on reasoning, problem solving and observational skills. Depth of knowledge and

the ability to apply this in a meaningful way to a range of situations was also seen as important. This is demonstrated in the following extracts:

*“Yes and also the ability to observe and interpret what you have observed and maybe to ask relevant questions because what you see could be due to the dementing process or anxiety, or whatever it is. ...”* (Occupational Therapists, FG 9)

*“I think that is what \*\*\*\* was saying that the depth of knowledge about dementia itself and how you apply what you know, sometimes it’s looking at things in a different way....”*(Community Nurse, FG 5)

Teaching, consultancy and sharing knowledge with other colleagues, carers and families was also seen as an important part of the specialist role:

*“I think we are very good at sharing information with the carers and explaining basic things with them in a way that they understand. Where, perhaps other people might think that they already know about it, or they have heard it before when actually nobody has took the time to sit down and explain”* (Physiotherapist, FG 14).

During the focus groups nurses often focused on more generic core skills, such as communication, counselling skills e.g. empathy/understanding and developing flexible approaches to person-centred care rather than profession specific skills. In some interviews the participants also referred to tasks rather than technical skills or

knowledge. Examples of these tasks included: *“depot injections, administering medication, organising the unit and supervising doctor’s reviews, etc”*.

Nurses working in more specialist or advanced roles such as community psychiatric nurses (CPNs) identified assessment, liaison and risk assessment as key skills. For example when asked to identify specialist skills the following discourse took place between two community based nurses:

*“So it’s monitoring, supporting ermmm, identifying risk because things change. Yeah, liaison as well, obviously reviewing frequently...”* (Community Nurse, FG 5).

*“Especially now, as the beds get less. If you look, I suppose at now what’s in the community compared to what was a few years ago, I bet a lot of them (referring to patients with dementia) there, that now would be in hospital wouldn’t they? Whereas now, they have to be managed at home. So there’s a big turn around as to what is considered a big enough risk to actually get yourself into hospital.”* (Community Nurse, FG 5).

The Health Care Assistants (HCAs) also perceived their work as being skilled. In particular they saw themselves as specialists in managing perceived challenging behaviour. Carrying out interventions around personal care and palliative care was also seen as central to the HCA role. This was recognised by the trained staff:

*“The fact that they spend so much time on the floor and you know, they are involved in a lot of personal care with them and they are observing them throughout the day. I think they are very, very good at picking up changes in people. You know, it’s not necessarily people saying that they feel unwell, but just a general change in demeanour or you know, they are very good.”* (Nurse, FG 4).

In contrast some health care assistants did appear to de-skill their work describing it as “*common-sense*” or “*being-sensible*”. It was work they felt “*anyone could do*”. They often described themselves as “*only nursing assistants*”.

In comparison with nursing staff, participants from disciplines such as Occupational Therapy and Physiotherapy were much more confident in articulating the specialist elements of their role. Occupational therapists were clearly able to define discipline specific skills such as activity and occupation, the retention of functional abilities, enhancement of capabilities and social integration. This is demonstrated in the following extracts taken from a focus group with occupational therapists working in a variety of settings:

*“So then it’s like grading tasks isn’t it, either grading tasks so that they can still achieve that task or being involved in that task rather than just being an observer or changing what’s around them so that they can still be functional”*(OT, FG9).

*“Sometimes, I do feel that.... Team members.... There’s kind of an ethos as you can’t do anything medically for them because it’s too advanced. It’s really just for social services. This was when I didn’t attend every M.D.T meeting .... And I had already identified some O.T issues to do with person-centred care actually. O.K, medically nothing is suitable but we can still offer this and this can still be beneficial and this can still promote the patient to enable them to do this that or the other (OT, FG 9).*

Physiotherapists were also able to identify a wide range of discipline specific specialist skills such as using tactile prompts, neurological knowledge, manual handling and knowledge of biophysical environment which they perceived as key.

#### b) Generic skills

Generic skills included effective communication skills, managing perceived challenging behaviour, activities and engagement, recognising symptoms of ill-being, maintaining independence and levels of functioning, supporting carers and their families. These were the skills that participants felt that all staff should have regardless of role or setting. Quotations are not illustrated here as they have been included in the framework in the previous chapter.

#### c) Skills for dementia care

Participants identified a wide range of qualities or attributes which they felt were essential in the delivery of person-centred (PCC). These included attributing value to people with dementia, respect for subjective experiences, a non-judgemental approach, patience, an emphasis on seeing the person as a whole, enabling and

empowering the individual with dementia and a person-centred approach.. The participants commonly used terms such as “*communication*”...“*respectfulness, calmness and dignity*” in relation to PCC care.

A flexible approach, adapting skills and knowledge according to the changing clinical picture and individual needs was viewed as particularly important when working with people with dementia. When asked how her practice would differ when working with older people who do not have dementia one participant noted that it was the ability to tailor treatment to individual’s needs rather than following a particular protocol:

*“I think it’s almost like, you would do exactly what you have been taught in university so you would assess them in this way and you would treat them in this way and everything would kind of almost follow a protocol. There would not be as much room for individuality. You would still tailor your treatment but it would be very regimented”* (Physiotherapist, FG 14).

*“You see the individual rather than the their condition and tailor communication accordingly but give them that respect, you convey that respect with what you say and what your approach.....”*(Nurse, FG 1).

Cultural competence was also raised as an important issue when working with people with dementia and their families. This was viewed as a central element of person-centred care:

*“But you definitely need to know about the culture before you actually....because if you are going to go into that person’s home you can’t just treat them as 1 group. You need to know something more about that community” (Nurse, FG 15).*

*“Well, the diversity within the person is unique to them and if you work within a listening way then and you have a recognition that there are things that you may not understand but I think that is true, you know of the lady who was born and brought up in..... I can’t assume what her life would have been like, but if you work in a person-centred way, I am going to gather her history and gather what makes her happy, what makes her sad, what makes well being achievable I may have had” (Nurse, FG 15).*

#### d) Gaps in knowledge

Staff clearly articulated gaps in knowledge a wide range of common categories emerged which included:

*Recognising dementia subtypes (Unqualified Staff)*

*Counselling skills*

*Causes of confusion*

*Administering neurological assessments and interpretation of assessments*

*Managing and identification of causes and triggers for behaviour which challenges*

*Managing physical ill health*

*Nutritional needs*

*Tissue viability*



*Managing epilepsy*

*Managing continence*

*Care planning*

*Activities and engagement*

*Cultural Competence*

There appeared to be a lack of knowledge and understanding of the dementia sub-types:

*“I think that is lacking in a lot of qualified staff. They see dementia as dementia. I mean, I have asked to do a couple of teaching sessions to students and they really haven’t got a clue about the different sorts of dementia that you get. I mean, there is such a variety with so many different presentations and that’s the skills that is lacking” (Unit Manager, FG 10).*

*“If you can’t define what it is how can you define it to a client or the family? You are struggling. So many times somebody has said to me what’s the difference between memory problems and forgetting..... And it makes you look an idiot. These are the sorts of questions people will come up with out of the blue” (OT, Technical Instructor FG 12).*

*“Yes, and if there was a more comprehensive training about dementia for other staff then maybe labelling people as having a behavioural wouldn’t happen as they know that’s what people with that type of dementia do” (Physiotherapist, FG 14).*

Cultural competence was another area of concern for some staff and caregivers who felt that staff were not equipped with the skills to meet the needs of the diverse and changing black and minority ethnic communities in the West Midlands:

*“We haven’t had an agenda or an understanding of the needs of Polish elders or any other Chinese group or whatever. You know with these groups we don’t even have representative in our workforce” (Nurse, FG 15).*

Although participants identified cultural competence as central to Person-centred care they also felt there was a need for basic awareness training around cultural competence:

*“Which we are trying to get away from that but staff are saying that we need that basic training again about people’s cultures, Instead of trying to group people. Like in terms of food not everybody eats the same sort of food” (Nurse, FG 15).*

Poor understanding of acute or medical interventions was also raised. This is demonstrated in the following extract where a newly qualified nurse discussed her concerns regarding managing patients with physical health needs:

*“I am glad you have brought that up because that is, we were discussing that earlier in the office. That is my main concern ...even though I have got my degree in mental health..... I didn’t feel competent enough to come onto a*

*ward... I saw someone having an elliptic fit and I didn't know what to do"*  
(Nursing Staff FG 13).

The participants were able to identify a number of courses which they could access, however discussion usually focused on statutory and mandatory training provided by the Trust. The participants did not appear to actively seek out training which would fulfil their needs or address identified gaps in knowledge. Instead they appeared to be directed by their senior managers when deciding which training they should undertake:

*"You know, I think we are pretty good here anyway. We have a training board and more often than not the manager will book you on them anyway. There are so many items on the board that she thinks is going to be beneficial to you go ahead and make arrangements you know... .."* (Nurse, FG 3)

A nursing assistant from an inpatient unit explains how she finds out about training which may be available:

*"Because that's not in the profession. Because where I came from the managers did it all and you knew what training you had to do... .."* (Health Care Assistant, FG 4)

Other members of the group add:

*“But I really think a manager should pick up all them things from training”*

(Health Care Assistant, FG 4).

Other staff felt that they could not access training which may have been helpful due to lack of funding or resources this is demonstrated in the following extract:

*“I think it’s to do with budgets and money rather than need”* (OT Technical

Instructor, FG 12).

There also seemed to be lack of clarity in the processes participants were required to follow when accessing training. Participants reported a sense of disparity and perceived lack of equity or fairness regarding funding training which had been requested:

*“The Trust brought 10 more places but all those went to Physiotherapists and out of those Physiotherapists none of them...I mean it was a £700 course all paid for by the Trust. None of them wanted to go on it. They were told that they had to do it. It was part of their role and like I am an O.T, exercise and all the falls prevention was part of it but we are the ones doing the extended groups”* (OT Technical Instructor, FG 9).

*“In terms of our development, is this...I am struggling to get on a course.....I have applied for it and I don’t place much hope on it. I was told by my manager fill it in”* (Nurse, FG 6).

Many participants felt that all staff should receive basic training in dementia care as currently this was not the case. In the following extract a physiotherapist discussed the needs of staff on an inpatient ward:

*“If everybody had got the same basic knowledge then they would understand where we are coming from. Their understanding would be better which would make our job easier. Another thing I am picking up on to do with medication, falls, and agitation plus everything to do with incontinence”.*

(Physiotherapist, FG 14).

Some staff, particularly those working at higher levels or in specialist roles, reported difficulty in accessing specialist training. This is demonstrated in the following extracts from 2 different focus groups:

*“It’s too generic isn’t it? Do you know what I mean?.....it’s not for us. It’s not specialist enough”* (Occupational Therapist, FG 9).

*“We can’t just pick something of the shelve”* (Physiotherapist, FG 10).

### Beliefs

a) The skills for person-centred care are “built in”

The belief that skills for person-centred care are “*built in*” or “*implanted*” was a major theme in ten out of the sixteen focus groups. Linked with this is idea that person-centred care is an “*attitude*” which cannot be taught:

*“I think it’s fair to say that the majority of staff have got it built in already otherwise they wouldn’t be here. The caring bit is built in or you could say already implanted” (Health Care Assistant, FG 3).*

*“Yes. Definitely..... I mean, I’m finding it quite difficult to kind of come up with ideas. I have been here maybe two months now and the nursing assistants that I come across, they are excellent, you know, they are very caring, they are very patient, you know. You can’t teach patience really, it’s just who and what they are really isn’t it?” (Nurse, FG 7).*

*“Some people that have been here donkeys years are about as patient centred as a goldfish and you can send them to patient centred training and they could be there for the rest of their lives and they still wouldn’t be. Whereas, with some people just seem to have a more natural idea” (Nurse, FG 10).*

*“First and foremost, if you haven’t got a caring heart and you care for this, for older adults with organic dementia, you never will” (Health Care Assistant, FG 4).*

*“I question how much you can teach somebody. I mean, yes ok you can sort of, you can say to somebody this is the way you should talk to people, this is the way you should lift, be patient cantered, that isn’t patient centred but you know, you send people on them, they come back and they behave in exactly the same way. They can all sit here around this table saying exactly how they*

*should behave, and they go out there and behave exactly the same way they were. And there are people who never do a patient centred care course that are fabulous with the patients. So I do wonder how much you can actually teach somebody” (Unit Manager, FG 3).*

#### b) Magical Touch

Many of the participants found it difficult to articulate, place or conceptualise their skills thus the idea of an “indefinable something” and “magical touch” emerged. This can be seen in the following extract:

*“Because we have some patients that have been like to other places and they came back to us, you know because other places can not cope with them. We have ermmm patients that come from other places and they couldn’t cope but when they come here ermmm we tend to meet the needs and the patient’s are so different in our environment then when they were at the other place. So we probably have some kind of magical touch.....”(Health Care Assistant, FG 3).*

On further examination it appears that “*knowing and understanding the person*” plays a key part in providing good quality dementia care and is often behind the idea of magical touch. In this extract the participants describe the significance of making connections and “golden rule” thinking i.e. putting yourself in the persons place:

*“Everything taking into account and when your doing with the patient and your also thinking ‘the good way is’ if this was me, how would I like to be treated a certain way..... I don’t want to be talked down to, I don’t want all*

*my choices taken away from me you know and I want to be treated with dignity.....” (Health Care Assistant, FG 1).*

### Barriers

There were a numbers of barriers identified which included time, staff shortages, lack of clarity regarding clinical role, professional confidence, feeling unsupported by colleagues, and a “top down” culture which can make it difficult to initiate change. The participants felt that these barriers prevented them from not only delivering high quality dementia care but also opportunities for new learning and development.

#### a) Time pressures and staff shortages

Some participants appeared to describe PCC as a task orientated and ordered process rather than based on individuals needs. They also felt that they had adequate knowledge and understanding of PCC approaches however were unable to implement this due to not having enough time or staff available. Therefore it was not a lack of knowledge which meant they could not deliver person-centred but other factors over which they had limited control. This is demonstrated in the following extracts taken from a focus group conducted within a continuing care unit:

*Nursing Assistant FG 2: “Person-centred Care doesn’t work in practice because of always shortages of staff and the different needs of the clients on the ward.”*

*Researcher FG 2: “So you feel it’s difficult-when you say PC care.....”*

*Nursing Assistant FG 3: “It’s difficult to implement it, you know you want to spend time with each client but you know but you know time doesn’t.....”*



*Allow you... ”*

*Nursing Assistant FG2 : “It’s very frustrating for us... ”*

*Group FG 2: “Sounds of agreement..... ”*

*Nursing Assistant FG 2: “I know I go on about the staffing an awful lot, but why is it that the elderly are always getting short staffed? Why is that so.....We do need the staff. To get things done. They make such a big deal of person-centred care. I meant here there used to be days when we did there nails, put rollers in their hair, put their make up on I mean those days have gone! They’ve got this big thing on person-centred care, you ain’t got time to do it half the time.”*

*Nursing Assistant FG 2: “Some parts was, as you said person-centred care doesn’t always work. We all want it to work, but its time consuming. There’s no way six of them (referring to patients with dementia) who are still asleep could wake up on their own, So natural waking is something we do on the person-centred care.... ”*

The participants also perceived that there was a “cost” associated with delivering person-centred care. They felt that if they set aside time for PCC this would mean they would not have enough time to complete other “essential” tasks. Person-centred care was therefore seen as a separate “task” rather than part of a holistic approach

which could co-exist with other activities. This is demonstrated in the following extracts taken from 2 different continuing care units:

*“I mean you couldn’t afford to leave them, those that want a lie in, in the morning you couldn’t afford to that, because you’d never get nothing else done, you’d be going back getting them up, going back getting them up as they wake individually. We just haven’t got the time to do that. I’m afraid you know we do go in and if they are asleep we might go back and leave them till last but they need to get up all in one swoop. They’re would be nobody up for dinner.”* (Nursing Assistant, FG2).

*“Because they need to be fed and everything. It’s very difficult when you’ve got 18 dementia patients up down round and about and you are trying to gather them altogether and you know, probably just 3 of us. One’s shouting, one’s trying to sit down, ones wondering... maybe...and you have to go and get him and you feel just whoa!!”* (Nursing Assistant, FG 3).

However this view was not shared by all the participants; some members did not see person-centred care as an add on but instead as a central and integral part of care as demonstrated in the following extracts taken from an inpatient continuing care unit. Here the nurses discuss how they interrelate with patients looking for opportunities to make connections during every interaction:

*“We have a lot to do with the patients from the time they get up in the morning. You’re constantly talking to them when you are dressing them, you*

*know you are giving them their meals so you talk to them as well Erm... in the afternoon when they have their afternoon drinks or if you've got a spare few minutes you might do their hair or all these things that are spending time with the client"* (Nurse , FG 3).

*"So you know we always find time, even if we're busy. We still always find that time to say hello or reach out"* ( Nurse , FG 3).

*"I mean nothings set in stone, and meal times, there suppose to be fun, I mean its easier in that sense to give them a leisurely bath..."* (Nursing Assistant, FG 2).

#### b) Personhood works both ways

The participants felt at times that they lacked control and had a low status within the organisation, undervaluing their role. In the following extracts three Health Care Assistants from a focus group conducted within an inpatient unit explain how they feel that their opinion is not valued by either qualified staff or medics and how this affects their practice and perception of the HCA role within the organisation:

*"They are not seeing their presentation (referring to patients). We are, but they will not actually listen to us (referring to nursing staff)... You are definitely fighting a losing battle, because you are on your own, even though you say that nothing gets done and you're thinking.....and has he changed it?"* (Nursing Assistant, FG 4).

*“And that’s how you find yourself ... Because I am a H.C.A. that’s why you are not listening to me. Well, that just makes you feel. That makes you feel angry you think what are you doing here.. Nobody listens to what you’re saying, so find you are just going to come and do. Just come and do your job and don’t actually care about the unit or anything. You care about the clients on a 1 to 1, but about the work environment and that...you’re like...Oh, I don’t care, I’m just coming to work You’ve got no passion for it and that’s what happens. You start losing your passion when people don’t listen to you and that really gets you down”* (Nursing Assistant, FG 4).

*“But you expect that. I mean, you don’t expect it, but you get used to it after a time and then you say to the consultants (referring to patients with perceived challenging behaviour) “What you’re giving him is not working..... It’s easy for you to say give them this, this and this. It’s not you out on the floor that’s dealing with the clients. So is there something else that you can do?” and I think that the consultants should listen”* (Nursing Assistant, FG 4).

The participants also felt that they were not valued by the senior staff with whom they work. This can be seen in the following discourse as two participants discuss what happened and how they felt following an incident of violence and aggression:

Nursing assistant FG 4: *“ ...one weekend, I got belted in the head, I got bit on the finger and I hurt my back, not my back but the thing....and ermm, I didn’t really get much response off management or anything err, I went of sick for 3*

*days which was due to work related injuries. I could have stopped off longer but there wasn't much support or anything"*

Researcher (FG 4): *"What would you like to happen in that situation?"*

Nursing Assistant (FG 4): *Well, if my colleagues got hurt and I was manager, I would say "Are you ok?" "Do you want to go home for the rest of the day?" Coz it does, you know, I mean "We can cover or "Are you ok to stay.... Go and take an extra hour off," or something or if you, know just a little bit of TLC support.....*

Nurse (FG 4): *"Because, you know what that in turn does? It makes you frightened of going about your job. Knowing that you have be clobbered/hit, as you put it, or whatever. You're just like, you want to stay away from that client and you start putting your hand up to say like, no you don't want no interactions with that person, but yet we are here to do that job and so it is very difficult and when you've got managers that don't even say "Are you alright?" You think, "What are you working here for really?"*

Nursing Assistant (FG 4): *I was gonna say, you may have a name and a little title. But really \*\*\*, I think you are just a number."*

Health Care Assistants also described feeling unsupported by qualified nursing staff. It appeared that they perceived the qualified staff to be preoccupied with other

administration, organisational or managerial tasks therefore unable to support them in delivering direct patient care such as washing and feeding:

*“That’s since I’ve started the paper work has double, trebled, and your thinking when have I got time for the patients. And I mean we are NA’s and it’s going to be worse for the staff nurses because they’ve got EPEX and everything now.”* (Nursing Assistant, FG 2).

*“They need to come out of the office and assist us (talking about qualified staff) which they don’t do because they know everything has got to go on the computer. But still, at the end of the day, if we didn’t have these clients, the paperwork you’re doing would mean nothing ”* (Nursing Assistant, FG 4).

### c) Role clarity and Professional confidence

Participants reported feeling unclear regarding their role. Participants described their role *“as a bit of this and a bit of that”* or even *“General dog’s body....taking charge of the ward”*. Participants also appeared lacking in professional confidence. This was a particular issue for nursing staff from both inpatient and community settings. This is demonstrated in the following extracts taken from both unqualified and qualified participants:

*“I think that our sort of accountabilities has gone up and up and yet our ability to make anything happen has gone down and down. Our status, in any group, I think we are probably... you know, well I think we don’t have any*

*status in any conversation compared to O.T ,and psychology. I often feel that, I don't know if you feel very side lined and as though your input isn't particularly... Do you ever get that feeling?" (Community Nurse, FG 5).*

*"You would think, as a qualified nurse working in mental health that you would have skills like counselling something like C.B.T but a lot of us don't have a skill do we? You know, in that way." (Nurse, FG 6).*

*"Like if some people have got bed sores or things like that er, yeah you can have training on all that. but sometimes it might not be the right dressing or something , they might be wanting to put something else on it and you haven't actually been told that, so when there is things like that you need to ask anyway you don't just assume that this is what you do. You know we are only HCAs at the end of the day. (Health Care Assistant, FG1).*

Other disciplines such as physiotherapy and occupational therapy were more secure in being able to define professional boundaries and when asked about relevant skills had no problem in discussing these. This can be seen in the following extract:

Researcher (FG 14): *"When you have had that sort of training do you feel confident to use that approach... solution focused?"*

Occupational Therapist: (FG 14): *"Yes. I think, it's sometimes it's once you have done a lot of role plays, in the solutions-focused we did a lot of role*

*plays that enabled us to test that and the more you do it the more it becomes like your practice about asking all sorts of questions”.*

#### d) Culture

Staff found it difficult to initiate change within the organisation, this evidenced in the following discourse between three participants which took place on an inpatient assessment unit following a recent training course:

Nurse (FG 6): *“You know, they come back and introduce a new form and then take it seriously because they have just been on this course and they have taken the advice and they come up with things and I think here, I feel my whole time in the trust, it’s very hard to introduce new forms o anything really. There’s always a major delay.”*

Nurse (FG 6): *“Isn’t there? And by that time your enthusiasm has gone down.”*

A participant also discusses how it is important to have the opportunity to use the new skills you have developed when returning to practice following a course. In this extract she is talking about Dementia Care Mapping Training:

*“That’s what I mean, because then I wouldn’t have forgot what I have learnt. You had to do the course, the you got a certificate but then you had to go on and to completely pass it, you had to go and do some mapping, but the*



*opportunity never came up. And I was a staff nurse and all the more senior were doing the mapping around the trust.” (Nurse, FG 8).*

#### e) Environment

Participants perceived the environment as stressful and challenging. Emotional labour included “*counselling*”, “*advising, negotiating between individuals and other patients/family/the outside*” and generally “*comforting people through illness, fear and upset.*” The nursing assistants and trained nursing staff working within the inpatient settings reported that they found their roles were particularly stressful, it also appeared that more stress was attributed to individuals who were perceived to be particularly challenging or physically dependant:

*“Erm, if they are .. I all depends on how independent they are and what their skills are and ... because if they are quite dependent, it’s quite challenging shift. This building at the moment how it is, I would say more so here than what it was previously hmmm (Nurse Assessment unit, FG 4).”*

*“.... It’s a very challenging area to work in and you may well be empathetic usually but it requires more from the person and understanding that you know, it does take it out of you. You need to look after yourself as well.” (Nurse, FG 7).*

#### Enablers

Enablers included mutual support from colleagues, job satisfaction, and connections with individuals with dementia were also perceived as facilitating high quality person-centred care.

a) We Care

Making connections with individuals with dementia and their families was also seen as enabler. The participants frequently spoke about the strong emotional ties which they developed and “we care” was a major theme throughout the focus groups. This is evidenced in the following extracts:

*“There are times in the day that you say “Oh I’m too old for this job, I just don’t wanna...” but you still come back, you do care for them, you have got patience with them. We do care. We do have a laugh for them. We create a good environment, we ...They are like a family to us, even when they do leave”* (Nursing Assistant FG 4).

b) Mutual support

Mutual support from colleagues was viewed as an important source of job satisfaction. The Participants also perceived mutual support as highly significant and an important means of managing stress. This is evidenced in the following discourse:

*Yeah a lot of team work within a ward, we’re always helping one anothe.”*  
(Health Care Assistant, FG 1).

### c) Job satisfaction

Participants also took great satisfaction in caring for individuals with dementia. Participants who reported high levels of job satisfaction appeared to find “joy” in their work, looking for rewards in caring, this was accompanied by feelings of self-esteem and vicarious happiness. Participants appeared to enjoy the feeling of being stretched and “*knowing that you had done something meaningful*”. These staff reported higher levels of job satisfaction in comparison to staff who looked for external rewards from the organisation. For example in this extract which was taken from a focus group conducted on a continuing care unit participants discuss how they derive “job satisfaction” from providing personal care:

*“To see them happy, it kind of gives you know. It, You’ve done something you have give something back, sort of thing. That thing you need.”*(Nurse, FG 3).

## Ways of Learning

### a) Learning from experience

Participants valued learning from experience and learning by doing. Staff described how they had learnt their skills “*on the job*” usually through working with more experienced staff. Participants looked for positive role models who they identified as “*trainers*”, other staff whom they would look up to. On occasions negative role models were identified who “*get the job done quicker*”. Positive role models or “*trainers*” appeared to have certain characteristics, “*they had done it for years*” “*expect high standards*”; they were also perceived to “*have got it*” in terms of being patient centred. This is demonstrated in the following extracts:

*“It’s a god send to be fair. They know what they’re doing, and you can watch em. There’s no point just watching them once or twice, you’ve gotta really watch them. You gotta think oh I’ll do that next time, or I’ll do that next time you know..”* (Nursing Assistant, FG 2).

*“You also find the more mature ones are better at it as well. The youngsters don’t won’t to know, which is another worry because once were gone and we’re of a certain age we always say when we retire, but we know our post won’t get taken (chuckles)”* (Nursing Assistant, FG 2).

*“Cos I’ve been so fortunate that when I started off I’ve always worked with excellent people that’s taught me the correct and good ways of nursing you know.”* (Health Care Assistant, FG 1).

*“That’s what I am saying, you do pick it up over the years..... you know that part of the brain is damaged and that’s why they have this behaviour...Yes. It takes many years to pick up. If there was one course you could go on, that they spoke about all the different ones and types of behaviours.”* (Nurse, FG 6).

*“I think that when you are at Uni and you are training to be a nurse, you briefly cover all the physical conditions but if you then don’t go into that field of expertise, that information is more or less lost and when you do decide on what area you want to work in, that’s when you*

*really learn, I think and build your skills up.” (Occupational Therapist, FG 9).*

*“To learn more about this client group as you work more with them, you build up techniques. You learn techniques don’t you? I suppose you all learn a different way.” (Nurse, FG 6).*

b) It can’t be taught

The nursing assistants seemed to have little value for qualifications or training. Formal training was viewed by some as unnecessary and resistance to it was strong. The nursing assistants felt that they had already been trained already by the “trainers”. They also felt they knew more than the external trainers as they worked with individuals with dementia everyday. They claimed that the way practices were taught in the classroom did not “fit” with their daily work and felt that the external trainers were out of touch with the “real world” describing them as “outsiders”. This can be seen in the following extracts:

*“Like I said it’s not effective on the actual unit, it’s ok from the classroom on the board where they’ve got all there information from the internet. But they need to come and do it for real, because you don’t.....You do role play on a course, it’s totally different in the ward.....Because when you role play getting them up, they don’t start biting, or punching, or kicking ya..” (Health Care Assistant, FG 4).*

*“ I’d say like 60% of it is no good to us. I mean the way you sit and talk, I mean you just can’t do that here. Their still looking for their mother at the age of 70, I mean you can’t talk em down. It doesn’t relate to us. And some of the holds you can’t use because their too fragile...”* (Health Care Assistant, FG 2).

*“I went on a food course, and the most interesting part was when....., she explained how people swallow and all that which actually was interesting and does relate to you.”* Health Care Assistant (FG 2).

*“(interrupts) oh yeah I went on that one... it was about giving people choice...you can’t ask them because you get one choice of dinner, and then your suppose to all sit round and chat!”* Health Care Assistant (FG 3).

Participants did however want training on practical tasks such as feeding. They thought this would be particularly valuable especially for new staff joining the unit:

*“They should give us a course on how to feed. I mean..... joined us recently, and I taught him how to feed, he’d never fed an adult, and that can be quite daunting. And he sat with us a couple of meals, until he picked up how to feed an adult. You know I think they should have a day like that for the younger ones.....”* (Health Care Assistant, FG 2).

Trained nursing staff also felt that health care assistants should receive more formal training:

*“Personal care for people with dementia, you know and techniques that can be used and what it is? Because I know they have a lot of on the job and you pick it up very quickly. But I don’t think there is any kind of formal” (Nurse, FG 7).*

#### Findings of focus groups with carers

Three themes emerged from the focus groups conducted with carers including “a caring nature”, approach and kindness and patience. Carers stated that they wanted staff that were:

- Knowledgeable
- Skilled in terms of the dementia diagnosis and processes
- Demonstrated a caring attitude
- Demonstrated common sense

##### a) A “caring nature”

The carer’s views echoed many of the themes identified in the focus groups held with clinicians. Carers valued staff who they perceived to “*have got it*” in terms of being person-centred. Carers described nursing as a “*vocation*” and felt staff needed to have a “*good heart*” and a “*caring*” nature. This is illustrated in the following extracts:

*“It would be great if nurses nursed from the heart, when we mention about all these qualities people have and that is said to me so often .....” (Carer , FG 16).*

*“It’s a vocational job. You have either got a vocation to do this. I think a lot of people just do it to earn money and some people do it because they love it” (Carer, FG 16).*

*“I think also, it doesn’t matter how much how much training you’ve got or it doesn’t matter how much skills you have got. It’s knowing how to use those skills” (Carer, FG 11).*

#### b) Approach

They also identified approach as key; one carer described the staff as having “winning ways”. When asked to elaborate she explained how staff “*can read the patients*”..., “*understand that they are all individuals*”. Another carer described staff as having a “*knack*” in using their experience skills to deescalate situations, this demonstrated in the following extract:

*“The staff have the knack that when somebody is kicking off the way they are able to move in and just hold their arm in a kind way and say come on, you come with me and away they go. You have got to see it. It’s hard to explain but you have to... but when you are sitting with somebody, you know and you see what goes on with others and it’s just the way they move into a particular situation and I don’t think that there are two patients the same and I don’t think there are two situations the same. It’s being able to read that situation and being able to quietly walk in and get the best out of the patients and within a few seconds they are calmed.” (Carer, FG 11).*



### c) Kindness and Patience

Carer related approach to the ability to listen and understand, create a warm atmosphere, and demonstrate respect and empathy. “*Kindness*” and “*patience*” were also identified as an important quality’s as illustrated in the following discourse:

*“The kindness that they show the patients. How you would like to be treated yourself”, (Carer FG 11).*

*“It’s the patience of the staff as well. The time that they spend....” (Carer, FG 11).*

*“It would be great if nurses nursed from the heart, when we mention about all these qualities people have and that is said to me so often .....” (Carer, FG 11).*

*“It’s a vocational job. You have either got a vocation to do this. I think a lot of people just do it to earn money and some people do it because they love it” (Carer, FG 11).*

### Summary

The findings of the focus groups have been presented in this chapter. The strengths of this work include the large number and range of participants who took part in the group. In addition as steps were taken to ensure the anonymity of the staff who participated in the groups it was felt that these were an honest account of their experiences of working with people with dementia. Weaknesses identified include that although the focus groups were conducted with a wide range of staff from a variety of disciplines it was not possible to conduct focus groups with staff from

psychology or medicine. Staff from these groups were invited to attend focus groups however due to organisational difficulties they were unable to attend.

Nursing staff struggled to define “specialist skills” however they were able to describe a range of generic competency based skills such as communication and approach which were viewed as important in order to provide high quality person-centred dementia care. Other disciplines such as Occupational Therapy and Physiotherapists were more confidently able to articulate discipline specific and specialist skills. Gaps in knowledge were also identified by staff such as cultural competence and physical health care interventions. Beliefs surrounding the skills for person-centred care also emerged such as the skills for person-centred care being “built in” or implanted and the idea of “magical touch”.

The participants discussed the perceived barriers to delivering high quality person-centred care such as staff shortages and time; however they also identified enablers such as mutual support and job satisfaction. Finally ways of learning were identified including “learning from each other”, “learning from experience” and “learning by doing”. The focus groups conducted with carers demonstrated that family caregivers wanted staff who were knowledge, skilled and able to demonstrate a person-centred approach with personal qualities such as empathy, kindness and patience highlighted as particularly important.

## **Chapter 4**

### **DISCUSSION**

#### **Introduction**

This chapter presents a discussion of the thesis overall. It begins with a reminder of the aims, followed by a critical discussion regarding the methodology that was used, a synopsis of the main findings which emerged and links to previous literature. The implications of these findings are then considered including the development of an innovative approach to the delivery of dementia care training which is based on the research findings. The chapter finishes with a number of recommendations which include that educational programmes should be developed for all three identified levels of practice, including programmes to meet the needs of staff working in specialist roles with people with dementia and their families.

The overarching aims of this research were firstly, to identify training competencies required to deliver dementia care in line with current NHS dementia care policy and secondly, to gather evidence on staff views of learning and skill development in order to give recommendations on the delivery of training.

In order to develop the competency framework it was necessary to develop an in-depth understanding of the roles within the service. Several different data collection methods were used in order to achieve this. These included semi-structured interviews with key clinical leads, followed by a questionnaire-based survey and focus groups conducted with a wider sample of staff. Content analysis (Donavan and Sanders, 2005) of the responses was then used to produce the framework, integrating the findings with those of previous frameworks.

Thematic analysis was felt to be the most appropriate for understanding the training needs and training delivery perspectives of staff within the service and was chosen to investigate the secondary aim; focus groups were selected as the most suitable method of data collection. Within these groups the roles of staff who work with people with dementia were explored. The participants discussed the skills, knowledge and attitudes which they felt were required in order to carry out their roles. The participants were also asked about their experiences of training, and to generate ideas regarding future training or improving training outcomes. In total 70 participants took part in the focus groups, including qualified and unqualified staff from a range of disciplines. Two focus groups were also conducted with 16 caregivers. The analysis was based on Interpretative Phenomenological Analysis (Willig, 2001).

A number of key findings have been drawn from the analysis. With regard to the first aim of developing a competency framework, staff identified a wide range of competency based skills. These were grouped into three levels of practice which were labelled as generic, specialist and advanced. It was noted that identifying profession specific skills was difficult for some staff particularly those from nursing backgrounds, and this seemed to be related to a lack of confidence in their professional identity.

Interestingly, the focus group conversations seemed to reveal that staff believed that the skills for person-centred care were built in and could not be taught. In addition, some groups of staff found it difficult to identify their skills and thus the idea of “magical touch” emerged. Staff identified barriers and enablers to good practice.

Barriers included staff shortages and time pressures, the culture of the organisation and lack of role clarity and professional confidence. Stress, burnout and emotional labour were also identified as barriers. Enablers included making connections with people with dementia, mutual support and job satisfaction. The findings suggest staff value learning from experience, learning by doing and learning from each other.

### Appropriateness of the methodology

#### Development of competency framework:

Through comparing and contrasting the outcomes of the interviews, the survey and pre-existing relevant frameworks (as well as the focus group material where appropriate), a total of 129 competencies were identified. Content analysis was used to produce the framework (Donavan and Sanders, 2005). The competency framework relates to real activities conducted in the work place and includes all knowledge, skills and attitudes that staff thought were needed to provide a good specialist service. Meretoja et al. (2004) argue that criticisms of competency frameworks may arise from poor practice in their development or lack of understanding of competencies. Meretoja et al. (2004) suggests such criticisms do not challenge the need and usefulness of competency frameworks but highlight the need for care and understanding when developing and implementing competency frameworks. In this study it is argued that a number of steps were taken to avoid pitfalls and enhance quality, including triangulation of the competencies using a range of sources (interviews, survey, literature and focus groups). Only a small number of questionnaires were returned by staff, and the focus groups did not include staff from medicine or psychology. However, these professions did participate in the interviews with key clinical leads and staff survey.

### Development of training recommendations:

With regards to the second aim of exploring staff views of preferred ways of learning, a phenomenological approach was chosen as it is highly suited to answering “what” and “how” questions about human issues and concerns, and can enable the development of understanding relating to a particular topic (Leonard, 1984). The analysis was based on Willig’s (2001) summary of IPA however due to the large sample size, the need to draw from perspectives across a range of disciplines and service settings and the pragmatic need to draw out fairly general conclusions and focus on training needs there was not an opportunity to undertake a full application of this method. These factors were given priority over the rationale for a nuanced phenomenological account. Larkin (2006) suggests an IPA study usually involves a highly intensive and comprehensive analysis of the accounts produced by the participants. Smith et al (1999) also argues that the purpose of IPA is to attempt as far as possible to gain an insider perspective of the phenomenon being investigated, whilst acknowledging that the researcher is the “primary analytical instrument” (Fade, 2004, p648).

Researchers “bracket out” their preconceptions (Colazzi, 1978). Husserl draws from two different versions of “epoche”, first “universal epoche” which, requires the phenomenologist to lay aside existing assumptions regarding the outside world second “local epoche” which, requires the researcher to bracket particular existing assumptions, depending on the issue to be clarified (Giorgi, 1985). The reason for such efforts to maintain “objectivity” can be traced to the history of qualitative research (Dowling, 2004). Murray (2003) recognises that it is important for the

researcher to acknowledge and address any preconceived assumptions or biases regarding the population or phenomenon under study. According to Larkin “it is the recognition that it is not actually possible-even if it might be desirable to remove ourselves, our thoughts and our meaning systems from how things “really are”.....in some definitive sense” (2006, p.106). However Larkin (2006) argues that this should not daunt us from making an attempt.

The researcher was part of the organisation working in the Trust’s Research and Innovation (R&I) Department and had previously worked within the organisation in a number of roles which enabled her to have a shared sense of identity with some of the participants. Having worked as a clinician she had also had predetermined ideas about what staff might consider useful in terms of training. However she had never directly worked with any of the teams or participants who were interviewed and her last clinical role within the organisation had been some years prior to this study in 2003.

The research could not be undertaken elsewhere as the focus of this thesis was established by the West Midlands Strategic Health Authority who agreed to pay the Trust to undertake the project. It was therefore necessary to demonstrate awareness and understanding of the need to protect potential participants, initially by approaching them in a way that avoided any pressure or coercion and also by ensuring that the aims of the study were made explicit. I adopted the process of “*epoche*” (Giorgi, 1985) consciously laying aside her preconceptions and reflecting on her ability to do this. I was able to address my presuppositions through use of a reflective diary and during clinical supervision this enabled me to listen to the stories of the

participants in an empathic, sensitive and accepting manner. I was particularly surprised by the staff's attitudes towards the organisation, their managers and current training as these were often negative. In the early phases of the project this was at times difficult to manage as I was also a part of the organisation.

Reflexivity may also be viewed as a tool which enables the researcher to formally acknowledge his or her interpretative role (Fade, 2006). A reflective diary was used so as to develop reflexive thinking. This included notes regarding the conduct of each focus group, and how it had progressed, along with additional observations and non-verbal communications. This reflective diary helped the researcher to capture and reflect on prejudices or presuppositions which may have affected the research. (See Appendix 10 for example of reflective diary). At the time of conducting the project I myself was experiencing difficulty with a line manager from the older adult directorate who I found to be controlling and undermining, it was therefore important that I avoided imposing my prejudices regarding the style of management within this directorate in the conduct of the focus group. It was therefore particularly helpful to have a colleague co-facilitate the focus groups who was a member of another organisation.

Other specific strategies were identified to ensure methodological rigour. In order to enhance the credibility of the study the researcher engaged in respondent validation. Guba and Lincoln (1981) suggest that the truth value of a qualitative study should be evaluated by its credibility rather than internal validity as in quantitative studies. Appleton (1995) asserts, "that credibility can be achieved by taking data and interpretations to the sources from which they were drawn and asking whether they



believe or find the results plausible” (p 995). The researcher conducted two interviews with 8 staff from 2 different settings who had participated in the focus groups. During these interviews the key themes which had emerged from the focus groups were summarised and discussed with the participants. The staff reactions were very positive and the group frequently used terms such as “*You’ve got it*” and “*That’s right*”. In addition two experts also reviewed the transcripts from the focus groups and gave their opinion of emerging themes. According to Cormack (1996) the use of independent experts to review data enhances the validity and reliability of the research. These experts provided consistent and at times challenging feedback on the analytic process, for example I was encouraged to include staff from a range of different settings in the focus groups meaning it was necessary to increase the number of focus groups.

Focus groups were used to collect the data and occurred following the interviews with clinical leads. Willig (2002) considers the focus group to be a group interview that uses interaction among participants as a source of data; the researcher takes on the role of a mediator gently guiding the discussion. The participants were seen as a homogenous group to the extent that they work in the same environment and therefore share experiences (e.g. of caring for people with dementia on a particular ward). In order to ensure a further degree of homogeneity, wherever possible focus groups were conducted separately with qualified and unqualified staff and different disciplines were also interviewed separately. The strength of the focus group as a method of data collection lies in its ability to allow participants to respond to and comment on one another’s contributions (Willig, 2002). It was indeed found to be an excellent method of data collection as the participants appeared to be open and honest about their

experiences and were observed to feel comfortable discussing difficult and sensitive topics such as when participants had been subjected to serious incidents of violence and aggression. Therefore disclosure seemed to be enhanced rather than inhibited through the presence of other participants. Perhaps this indicates something of the closeness of the bonds and mutual support experienced by those who took part. (Mutual support was an overarching theme which emerged from the findings of the focus groups). Staff were also given reassurance that steps had been taken to ensure their anonymity, as all participants were assured that the data would remain confidential and that their identity would be protected.

A total of 16 focus groups were conducted. The texts from the focus groups were analysed one by one taking an idiographic approach whereby insights were produced as a result of intensive and detailed engagement with individual transcripts.

The disadvantage of the approach was that it was extremely time-consuming in terms of data collection (e.g. organising the focus groups) and in-depth analysis as a vast amount of material was generated.

### Project Findings

The findings from the focus groups will be discussed under a number of main sub-headings: Competency based skills, professional confidence, identifying gaps in practice, the skills for person-centred care are “built in” and finally ways of learning.

### Competency based skills:

The findings from the focus groups contributed to the development of the competency framework. Material emerged during the focus groups regarding the competencies perceived as essential to work with people with dementia. This material was included in the development of the competency framework and was integrated into the final framework (please refer to figure 4).

Three different levels of practice were identified: Generic, specialist and advanced. These levels were identified through a deductive process and emerged during the analysis of the research findings including the interviews, questionnaires and staff survey. Although it was originally anticipated that the competencies framework would not be a hierarchical structure those staff interviewed that had specialist competencies were generally professionally qualified (see cluster diagram appendix 11).

The competencies which were identified as specialist were predominantly found to be associated with 3 of the 8 clusters. 1) Advanced assessment; examples include advanced assessment and diagnostic skills, understanding the psychological consequences of cerebral or physical disease and understanding the psychological and emotional impact of diagnosis; 2) Delivering psychological therapies; examples include determining psychological formulations and delivering evidence-based dementia focused interventions e.g. validation therapy, reminiscence, life review, Cognitive stimulation (CST), Cognitive Behaviour Therapy (CBT), Reading for Well-Being. Or 3) Clinical leadership; examples include demonstrating a high level knowledge of research evidence in relation to dementia and dementia care and demonstrating advanced skills in research and evaluation and ability to undertake

research projects/service evaluations/audits. This may provide evidence regarding the distinct strengths and roles of a specialist mental health service.

The findings illustrated that participants frequently found it difficult to identify their specialist skills, although a wide range of skills and in-depth knowledge regarding working with people with dementia was evident during data collection. There is some evidence to suggest that a possible explanation for this might be the idea of “unconscious competence” where staff are working so effectively and skilfully that it becomes second nature. The conscious competence model posited by Maslow (1940) includes stages of learning, progressing from 1. Unconscious Incompetence (you don't know that you don't know something), to 2. Conscious Incompetence (you are now aware that you are incompetent at something), to 3. Conscious Competence (you develop a skill in that area but have to think about it), to the final stage 4. Unconscious Competence (you are good at it and it now comes naturally) (Dubin, 1962).

#### Professional confidence:

Lack of professional confidence was an issue for some individuals particularly those from nursing backgrounds. Professional confidence is about possessing the confidence, belief and ability to do your job effectively (Adams, 2008) and is related to being able to make decisions independently and being open to new ideas or evidence (Cowen, Moorhead et al. 2004). Self-efficacy also corresponds to a person's belief in their own competence and is a key element of social cognitive theory (Bandura, 1977) and appears to be an important variable because it affects student's motivation and learning (Dinther Dochy and Segres (2011). There is a lack of

research evidence exploring issues of professional confidence and models for developing this, although Wattson, Hockley and Dewar (2004) demonstrated that nursing staff, who acquired additional knowledge of interventions for the management of patients with dementia in palliative care, developed new confidence in their role. Related to conscious competence, these staff also found ways to make their assessments of the care needs of patients more explicit to other practitioners, thus improving care. Nolan (2000) conducted focus groups with 50 nurses, and found they described feeling “disempowered”, and experienced a lack of continuity in the care for older people with mental health needs. The authors proposed that nursing had split into factions each with a poor understanding of the other’s role. In addition, heightened emphasis on psychological therapies also meant nurses no longer saw themselves as key players in the field. This has been identified as an issue for pre-registration nurse training.

The findings suggested that nursing staff appeared to expect their line managers to facilitate learning rather than taking personal responsibility for addressing identified gaps in knowledge. The participants describe how they wait for a list to be posted on the training board or to be given a form by their manager. This demonstrates how staff may feel disempowered within the service. It is therefore possible that staff may need further encouragement to actively participate in or create learning opportunities once gaps have been identified. It may be necessary to use methods of formal self assessments of knowledge, skills and attitudes. Such methods are used in other professions including psychology. Identified learning opportunities will depend on individual learning styles but ideas for acquisition of knowledge suggested by the participants include reading journal articles, e-learning or utilising library resources.

The nurses interviewed in this study also found it difficult to identify profession specific skills, compared to those staff from other disciplines including occupational therapy and psychology. Lee-Treweek (1984) attributes this to development of nursing and argues that there is a central debate over what constitutes nursing work. In theory, nursing work is total patient care, holistic in nature. However in reality much nursing work is task oriented in which people become work objects to be processed, ordered and “routinised” (Melia, 1989, p31-38).

The nursing of elderly patients can be seen as marginal to present-day notions of nursing, as it involves a strong element of physical care work. Elderly care nurses may delegate such tasks to lesser status workers particularly in settings such as continuing care, thus making contact care work an even more marginal part of their role. Therefore “the elderly care nurse is faced with the dilemma of a lack of congruence between theoretical and practical care, and dealing with a lower status patient who is perceived within medical and nursing discourse as dull and difficult to care for” (Lee-Treweek, 1994, p 41).

#### Identifying gaps in practice:

In the focus groups unqualified staff identified a lack of knowledge and understanding regarding the identification of dementia sub-types as a gap, and participants also stated they felt adequate training in dementia awareness was essential. For unqualified staff this included understanding signs and symptoms of dementia and the impact of dementia on behaviour. The focus group participants from inpatient services focused on gaps of knowledge in physical care skills. This was a particular concern for newly

qualified staff nurses. These findings are reflected in the literature review as the report “Improving services and support for people with dementia” (DOH, 2007) strongly criticised specialist mental health services for their lack of knowledge and skills in managing older people’s physical health needs.

Other areas in which participants highlighted perceived lack of knowledge or skill included counselling skills, causes of confusion, administering and interpreting neuropsychological assessments, managing and identifying causes and triggers for behaviour which challenges or perceived challenging behaviour, cultural competence (the ability to interact effectively with people of different cultures), nutritional needs, tissue viability, managing continence, care planning, and strategies in activities and engagement.

#### Accessing training:

Staff in more specialist senior roles described finding it difficult to access training which met their needs in terms of offering specialist education/training rather than programmes more suited to generic roles. This was expressed as a particular problem for senior occupational therapists, physiotherapists and advanced nurse practitioner roles. There appeared to be a lack of specialized education provision, which has implications for education providers. The study conducted by Tsaroucha et al (2010) reported similar findings. Tsaroucha et al. (2010)’s recommendations included a need to ensure staff at all levels have access to appropriate training in order to ensure they are equipped for practice.

#### The skills for Person-centred Care are built in:

Participants perceived that the skills for person-centred care were “built in” or “implanted”. This was also a belief held by family caregivers. This may be related to the idea of unconscious competence discussed early in this chapter. Authors such as Lee-Treweek (1994) and Dingwall (1977) argue that such ideas reflect the ideals of nursing which were modelled on vocation and 'calling'. The Nightingale nurse was developed around Victorian feminine virtues, with the only necessary qualification being her moral status as a 'good' woman. The 'good' woman was a natural nurse with the maternal attributes of altruism, self sacrifice and caring (Garmarnikow,1978, p.103-116).

#### Ways of learning:

The participants spoke of finding it difficult to translate and apply class room learning to their practice. This is a central issue for teaching and curriculum design. The findings support the use of approaches based on active and experiential learning and also the use of problem-based approaches to learning delivered in-service. Participants valued learning from experience, learning by doing and learning from each other. These three aspects will each be discussed in turn:

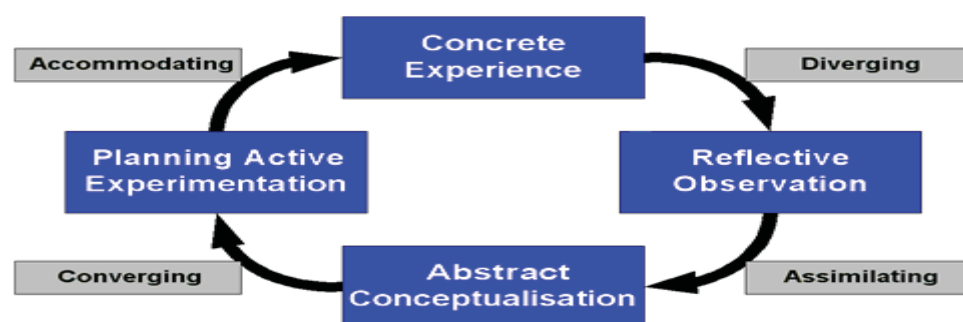
#### Learning by doing:

The findings suggested staff valued pragmatic learning or “learning on the job” as a means of gaining knowledge from observation and experience. Experiential learning is learning through “reflection on doing” and focuses on the learning process for the individual and more complex information processing (Palmer and Kimchi, 1986). The major proposition is that learners utilize different levels of explanation as they process



information. This is done on a continuum from perception, through attention, to labeling, and finally, meaning. According to Kolb (1984) gaining of knowledge is an inherent process that occurs naturally. Kolb (1984) developed a theory of experiential learning known as the Kolb cycle, the learning cycle or the experiential learning cycle. This comprises four different stages of learning from experience. It can be entered at any point but all stages must be followed in sequence for successful learning to take place. The learning cycle suggests that it is not sufficient to have an experience in order to learn. It is necessary to reflect on the experience, to make generalisations and formulate concepts which can then be applied to new situations. This learning must then be tested out in new situations. The learner must make the link between the theory and action by planning, acting out, reflecting and relating it back to the theory.

Kolb Learning cycle (1984) Figure 1.



This pragmatic approach to learning also appears to facilitate deep learning as opposed to surface learning. A deep approach to learning is characterised by the

learners' active engagement with the subject matter and the internalisation of new knowledge (Gibbs, 1992) or information processing. Deep learning is promoted by being able to transfer knowledge from the specific to the general, relate new information to old, generate high quality inferences and exhibit integrated problem solving plans. This is different from a superficial approach which is characterised by memorisation of information and procedures. Surface learning is often associated with didactic approaches to teaching (Gibbs, 1992). When material is only learnt superficially, the person often fails to perceive the subject relevance and is unable to use their knowledge in order to problem solve or apply their learning to real world situations. In this study, examples of this appeared to be found when staff used terms associated with Kitwood's approach to dementia care such as "objectification" or "malignant social psychology" without understanding their meaning. The language used in the focus groups indicated that they objectified the patients, so even though they were clearly familiar with the principles of PCC it would appear that they did not fully understand their true meaning, in order to apply this to their everyday practice. Gibbs (1992) identifies a positive relationship between a deep approach and qualitative differences in learning outcomes. Therefore it is important to move the content of training beyond the theoretical knowledge of dementia (Kitwood, 1997). Indeed Fook (1996) notes that being exposed or knowing a theory does not necessarily mean that it is integrated into the functioning and action of an individual.

Vygotsky's (1978) theories stress the fundamental role of social interaction in the development of cognition, and view interaction with peers as an effective way of developing skills and strategies. Vygotsky's work suggests that learning occurs during

situated activity or in authentic settings and that learning, thinking and knowing arise through collaboration with others (Samaras and Gismondi, 1998).

#### Learning from each other:

A further issue in the care of a person with dementia is team-work: “Caring involves the actions of people with dementia are resourceful aware, who can trust each other and work easily as a team” (Kitwood, 1997; p.103). Staff identified “mutual support” as an enabler in terms of delivering person-centred care and an important means of managing stress and emotional labour. The prominence of team work in the findings of the focus groups also supports and encourages the use of in-service training as this would ensure goals are shared by all members. Team teaching has also been found to be valuable to coaching in effective communication skills which are key in the provision of good quality care (Oliver and Endersby, 1994). The findings indicated staff learnt from modelling the behaviour of staff who they perceived to be experienced and expecting high standards. The principles of social learning theory are that people can learn by observing the behaviour of others (Ormond, 1999). The staff identified their own “trainers” within the clinical area. The trainers were experienced, expected high standards, and perceived by others to “have got it” in terms of being patient centred.

#### Learning from experience:

The findings suggest that staff feel trainers do not value their experience. Indeed, they expressed the view that they often felt they knew more than the trainers. As previously stated staff also found it difficult to relate theory to practice. Problem-based learning is a model which would address these issues. Within a problem-based

learning approach (PBL) the teachers/trainers take on the role of “facilitators”. PBL recognises the expertise of staff, creating an adult learning environment. The model is therefore useful as it appreciates that adults can be self-directed learners, with rich experiences and knowledge on which to draw, and a desire to learn to better handle real-life situations, and see education as a process that increases competence and leads to achievement of their full potential. Within PBL learning is driven by challenging, open-ended, ill-defined and ill-structured problems. Tackling these problems encourages learners to build on what they know. This is important since learning has been shown to be easier if it is building on existing knowledge and more difficult and disconnected if it does not link up with existing knowledge (Fraser, 2002). Learners generally work in collaborative groups and take on responsibility for their group and organize and direct the learning process with support from the trainer. Advocates of PBL claim it can be used to enhance content knowledge and foster the development of communication, problem-solving and self-directed learning skills (Kohet et al. 2008). By working through a combination of learning strategies to discover the nature of a problem, understanding the constraints and options to its resolution, defining the input variables, and understanding the viewpoints involved, learners develop skills which enable them to negotiate the complex nature of the problems which they may come across in clinical practice and also how competing resolutions may inform their decision-making. The problem-based approach has an extensive evidence base and is widely used in medical education and has been since the 1960s (Kohet et al. 2008).

#### A model for delivering dementia care training-“Home and away learning”

A new and innovative model based on “Home and Away” learning, is therefore proposed. This would be an experiential approach to learning using the principles of

Kolb's learning cycle, role modelling and the deep learning approaches described above. The content of the training curriculum would be based on the competency framework, and a problem-based approach to delivery of the curriculum would be recommended.

The model proposed builds on the team solidarity and mutual support highlighted by the focus groups. Cialdini (2001) suggests six principles of behavioural change, one of which is "social proof", related to social conditioning, that states that people look to the behaviours of others as a guide to what is fitting or normative behaviour. It is recommended that the training should take place on the unit or within a team. This is supported by Vygotsky's (1978) work which suggests that learning occurs during situated activity or in authentic settings. Furthermore, in order to connect new learning with prior experience, following the principles of deep learning, staff would be asked to identify a particular active problem/case/issue. The trainer would then work alongside the team to address this, encouraging staff to review the nature of the problem or difficulty and seek out possible resolutions, again in line with Kolb's reflective learning cycle. The trainer would be able to model person-centred approaches and values whilst working with the staff, thus making the distinctive skills clear and so enabling conscious competence to develop in the staff. In order to embed the learning in practice, a follow up visit would be conducted after the team have had an opportunity to reflect on the learning and test this out in a variety of situations. The findings from the focus groups suggest the trainers or facilitators should preferably be skilled clinicians of similar grades and job roles who are currently working within clinical practice as this will ensure they are viewed as credible by other members of staff.

It is suggested that this training intervention will facilitate the development of professional confidence and self-efficacy, self-esteem, acknowledgement of emotional labour, and will include opportunities for staff to address attitudes and therefore facilitate the development of emotional competence, empathy and a non-judgemental approach. According to social learning theory, there are four main sources of information that create learners' self-efficacy: enactive mastery of experiences, vicarious experiences, social persuasion and physiological and psychological states (Dinther, Dochy and Segers, 2011).

The model has been identified as particularly cost effective as staff will not be required to leave the clinical area in order to attend the training; therefore there is no requirement to backfill time or use bank or agency staff. Patients would also receive direct benefit as a result of the training intervention. Echoing the studies reviewed in the first chapter, means of evaluation could include patient quality of life measures, clinical audit including evaluation of care plans, and carer satisfaction surveys.

Kitwood (1997) identified five core principles of person-centred care: Comfort, attachment, inclusion, occupation and identity, and saw these as critical to good care. Kitwood also identified a number of aspects related to malignant social psychology or poor person-centred care. Ensuring staff understand these elements is a necessary component of dementia training interventions as this will enable staff to learn how to care for somebody in a person-centred way. The literature reviewed in chapter 1 demonstrates that this is an element frequently included in dementia care training (e.g. Fossey et al. 2006). Evidence suggests approaches to training may also be congruent

with a person-centred approach to dementia care. For that reason training may focus on the uniqueness of each learner and respect his/her individual needs (McCarron 2008, Sheard, 2008). Person-centred care is not seen as an “add on” but as an integral part of the care process. Sheard (2008) argues that a person-centred approach to learning should be experiential and involves a flexible approach rather than a prescribed learning programme.

Relationship, communication and empathy are at the core of person-centred care therefore training should reflect this. Consequently it is essential for trainers to foster a climate of openness allowing staff to display and discuss difficult emotions in order to develop emotional competence (Sandgren et al. 2006). Emotional competence refers to person’s emotional skills at handling emotionally charged and stressful situations (Sandgren et al. 2006). Resilience and emotional competence are also linked with an increased sense of job satisfaction (Motoes et al. 2010).

The findings suggest training strategies should also address the barriers to delivering person-centred care such as staff shortages and time pressures and help learners challenge and identify means of overcoming these. Training strategies can assist staff in identifying enablers, such as demonstrating how they can make connections with individuals with dementia, exploring ways to provide meaningful occupation and enhance well-being. Beliefs such as “it’s built in” and “magical touch” can also be addressed. The findings demonstrated magical touch is often related to knowing and understanding the person and experience rather than being a “magical” phenomenon. In terms of teaching a PCC approach Costello (2007) conducted a qualitative study which concluded health care staff can learn how to care effectively in small groups by

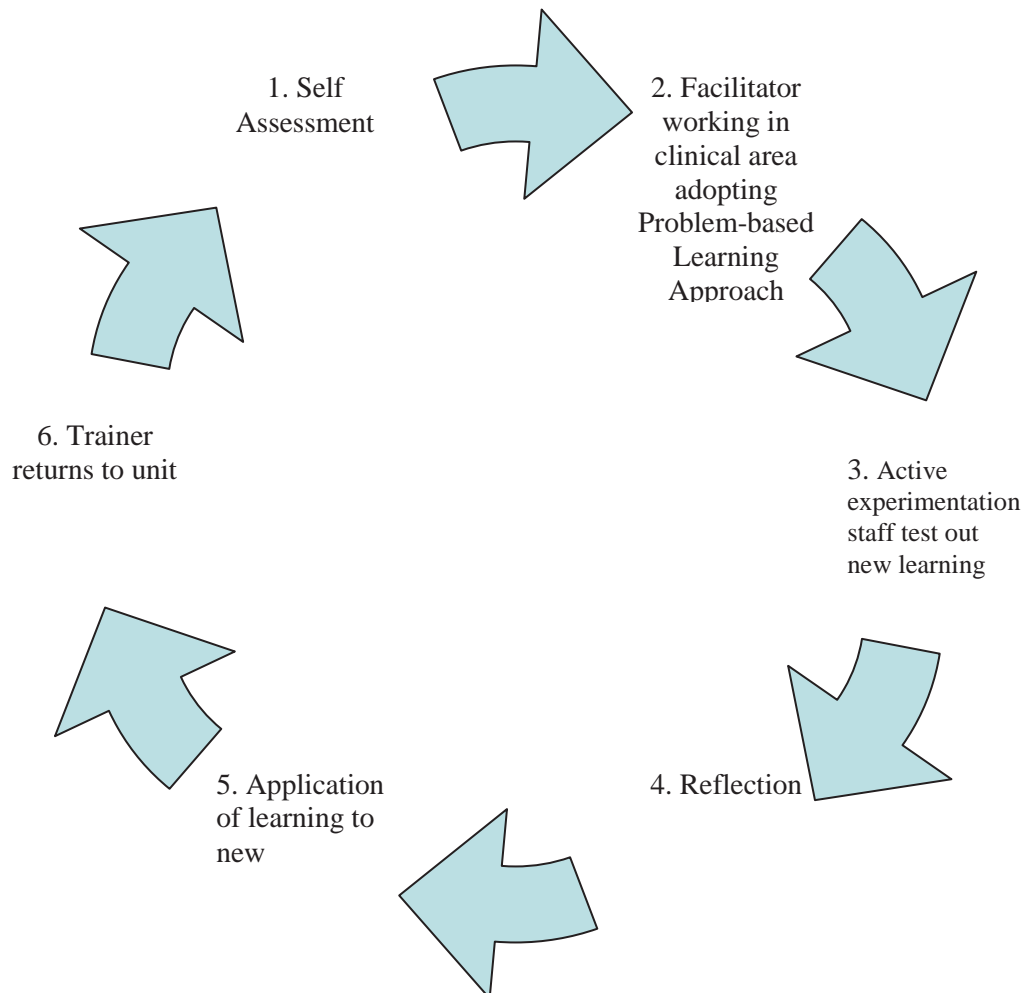
developing their emotional intelligence, self awareness and empathy, learning to engage with patients, and developing therapeutic relationships.

A web-based learning system would also assist learning. This could be completed by staff before the trainers visit the clinical area. This would provide staff with knowledge based information rather than skills based training in relation to dementia care. There are many web based packages in existence. Social care institute for excellence (SCIE) have developed an e-learning programme which includes packages on causes of dementia, living with dementia and diagnosis of dementia. Although there are disadvantages associated with this type of learning package, the system would be the “starting point”, supporting staff in developing the basic fundamental knowledge necessary for working with people with dementia. This could be used as a means of ensuring staff develop the knowledge based competencies.



## Home and away model

Figure 2.



## Accelerating the spread of good practice

As previously discussed the findings from the focus groups demonstrated that staff look for role models who they have identified as “trainers”. These are other team members whom they look up to and perceive as experienced and having “got it” in

terms of being person-centred. It is suggested this could be built upon in future training through the identification of “Dementia champions” or “Dementia stars” (Sheard, 2008) to guide, support and mentor other staff. This is a model that has been used within dementia care settings, though its impact has not been formally assessed.

Further methods in order to facilitate this process include a “case busting model”, peer group supervision and clinical supervision. These models encourage the sharing of knowledge and expertise and enable the recognition of other team member’s successes and encourage individuals to share the “secrets” of good practice fostering a learning environment and a culture of collaboration. Clinical supervision has been shown to benefit staff in terms of their job satisfaction, reduction in levels of burnout and perceptions of the quality of care (Hyrkas, 2006). The findings suggest staff members also need time to take a reflective approach to their work, developing awareness of what they are doing and why they are doing it. Buddying systems for new members of staff are already in existence within the division and these were highly regarded by staff.

Bringing about sustainable, productive changes in organizations is difficult. Motivation for learning and change is influenced by both intrinsic and extrinsic factors that can initiate sustain or intensify behaviour and there is a wealth of motivation theories. Intrinsic factors include the individual characteristics, predispositions, effort and values (Deci, 1972). Extrinsic motivation is related to outside the individual and may be related to meaningful incentives or rewards provided by the organisation (Vroom, 1964). Incentive theory suggests when people are offered the opportunity to accomplish specific valued purposes they will alter their

behaviour to attain these ends (Korman, 1973). Therefore behaviour is “shaped” by the person controlling reward allocations. Such incentives may include security of services, praise or recognition, job enrichment or promotion opportunities.

A related theory is that of “cognitive dissonance theory” Festinger (1957) which occurs when an individual experiences some degree of discomfort resulting from an incompatibility of two cognitions. It is often strong when we believe something about ourselves and then do something against that belief i.e. that if someone is committing to training they would have to match their behaviour with what they say in the training to avoid negative feelings. Cognitive dissonance is a very powerful motivator which will often lead us to change one or other of the conflicting belief or action. The discomfort often feels like a tension between the two opposing thoughts. To release the tension we can take one of three actions: Change our behaviour, justify our behaviour by changing the conflicting cognition, justify our behaviour by adding new cognitions. Dissonance is most powerful when it is about our self-image. Feelings of foolishness, immorality and so on (including internal projections during decision-making) are dissonance in action (Festinger, 1957).

Following intensive training interventions such as those described above. It is also suggested that on-going opportunities for providing teaching and collaborative learning opportunities should be identified and sought out, for example extended handover periods. This suggestion is supported by Vygotsky’s scaffolding theory (1978) which states that in order for learning to become internalised this should occur during the actual problem solving or shared task definition with others.

Figure 5. Psychological Mechanisms

Training Needs	Psychological Mechanisms	Competencies	Direct recommendations for training
Competency based skills	<p>“social proof” people will do things they see other people are doing (Cialdini, 2001)</p> <p>Cognitive Dissonance (Festinger, 1957).</p> <p>Role of social interaction strategies (Vygotsky’s, 1978).</p> <p>Experiential learning (Kolb Cycle, 1984)</p> <p>Information Processing (Palmer and Kimchi, 1986).</p>	Skills and knowledge based competencies including: Skills for working effectively with people with dementia; Advanced assessment skills and Delivering psychological therapies; Physical Well-being; Ethical and legal issues	<p>Experiential learning in the clinical area</p> <p>Peer/Clinical supervision</p> <p>E-learning package</p>
Professional confidence	<p>Self-efficacy/Social Learning Theory (Bandura, 1977)</p> <p>The conscious competence model ( Maslow, 1940)</p>	Clinical Leadership and Personal and Professional Development	<p>Experiential Learning in the clinical area</p> <p>Clinical/Peer Group Supervision</p>
Identifying gaps in practice and accessing appropriate training	Self-efficacy/Social Learning Theory	Clinical Leadership and Personal and Professional Development	<p>Experiential Learning in the clinical area</p> <p>Clinical supervision</p>

## Conclusion

The competency framework developed within this thesis, draws on a series of interviews with staff and a survey, to outline generic, specialist and advanced skills necessary for roles within specialist services. Issues around identifying discipline specific skills emerged for nurses and professional confidence was also a key theme. Gaps in knowledge were identified by staff. Inpatient staff focused particularly on knowledge in physical health care skills. Staff in senior practitioner roles reported that they found it difficult to access training to meet their needs in terms of offering specialist training/education.

A new approach to dementia care training is proposed which takes into account the views expressed by staff in the focus groups in this study. Learning appeared to be derived from learning by doing, learning by experience and learning from each other. Therefore the intervention will focus on problem-based approaches, experiential active learning, role modelling and maximising opportunities for collaborative learning, including peer group supervision.

## **APPENDECIS**

### Appendix 1: Search History

#### Search History

1. PsycINFO; ALZHEIMERS DISEASE/ OR exp DEMENTIA/; 36998 results.
2. PsycINFO; exp CLINICAL METHODS TRAINING/; 13163 results.
3. PsycINFO; (staff adj2 training).ti; 240 results.
4. PsycINFO; (staff adj2 training).ti,ab; 1712 results.
5. PsycINFO; (dementia OR alzheimer\*).ti; 27705 results.142
6. PsycINFO; 1 OR 5; 38228 results.
7. PsycINFO; 2 OR 3; 13337 results.
8. PsycINFO; 6 AND 7; 33 results.
9. PsycINFO; exp MENTAL HEALTH PERSONNEL/; 35865 results.
10. PsycINFO; exp TRAINING/; 44523 results.
11. PsycINFO; 3 OR 10; 44580 results.
12. PsycINFO; training.ti; 40979 results.
13. PsycINFO; 10 OR 12; 68628 results.
14. PsycINFO; 6 AND 9 AND 13; 3 results.
15. PsycINFO; exp HEALTH PERSONNEL/; 75929 results.
16. PsycINFO; 6 AND 13 AND 15; 53 results.
17. PsycINFO; 8 OR 16; 73 results.
18. CINAHL; exp DEMENTIA/; 21351 results.
19. CINAHL; (dementia OR alzheimer\*).ti; 13251 results.
20. CINAHL; exp HEALTH PERSONNEL/; 216190 results.
21. CINAHL; exp EDUCATION/; 324225 results.
22. CINAHL; training.ti; 18471 results.
23. CINAHL; 21 OR 22; 333216 results.
24. CINAHL; 18 OR 19; 21949 results.
25. CINAHL; 20 AND 23 AND 24; 433 results.
26. CINAHL; 20 AND 22 AND 24; 59

1. EMBASE; exp DEMENTIA/; 116052 results.
2. EMBASE; (dementia OR alzheimer\*).ti; 48400 results.
3. EMBASE; (dementia OR alzheimer\*).ti,ab; 85386 results.
4. EMBASE; exp MENTAL HEALTH CARE PERSONNEL/; 579 results.
5. EMBASE; (skill\* OR competen\* OR knowledge).ti; 30528 results.
6. EMBASE; 1 OR 2; 117021 results.
7. EMBASE; 4 AND 5 AND 6; 1 results.
8. EMBASE; exp HEALTH CARE PERSONNEL/; 295802 results.
9. EMBASE; 5 AND 6 AND 8; 63 results.

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2. EMBASE; (dementia OR alzheimer\*).ti; 48400 results.
3. EMBASE; (dementia OR alzheimer\*).ti,ab; 85386 results.
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7. EMBASE; 4 AND 5 AND 6; 1 results.
8. EMBASE; exp HEALTH CARE PERSONNEL/; 295802 results.
9. EMBASE; 5 AND 6 AND 8; 63 results.
10. EMBASE; CLINICAL COMPETENCE/; 3361 results.
11. EMBASE; PROFESSIONAL COMPETENCE/; 3926 results.
12. EMBASE; 10 OR 11; 7196 results.
13. EMBASE; 6 AND 12; 68 results.
14. CINAHL; exp DEMENTIA/; 21757 results.
15. CINAHL; (dementia OR alzheimer\*).ti; 13523 results.
16. CINAHL; (dementia OR alzheimer\*).ti,ab; 17562 results.
17. CINAHL; exp HEALTH PERSONNEL/; 220317 results.
  
18. CINAHL; (skill\* OR competen\* OR knowledge).ti; 26547 results.
19. CINAHL; 14 OR 15; 22421 results.
20. CINAHL; 17 AND 18 AND 19; 48 results
  
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2. EMBASE; (dementia OR alzheimer\*).ti; 48400 results.
3. EMBASE; (dementia OR alzheimer\*).ti,ab; 85386 results.
4. EMBASE; exp MENTAL HEALTH CARE PERSONNEL/; 579 results.
5. EMBASE; (skill\* OR competen\* OR knowledge).ti; 30528 results.
6. EMBASE; 1 OR 2; 117021 results.
7. EMBASE; 4 AND 5 AND 6; 1 results.
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9. EMBASE; 5 AND 6 AND 8; 63 results.
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11. EMBASE; PROFESSIONAL COMPETENCE/; 3926 results.
12. EMBASE; 10 OR 11; 7196 results.
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16. CINAHL; (dementia OR alzheimer\*).ti,ab; 17562 results.
17. CINAHL; exp HEALTH PERSONNEL/; 220317 results.
18. CINAHL; (skill\* OR competen\* OR knowledge).ti; 26547 results.
19. CINAHL; 14 OR 15; 22421 results.
20. CINAHL; 17 AND 18 AND 19; 48 results.
21. CINAHL; exp PROFESSIONAL COMPETENCE/; 22628 results.
22. CINAHL; 19 AND 21; 92 results.
23. BNI; exp DEMENTIA/; 2648 results.
24. BNI; (dementia OR alzheimer\*).ti,ab; 3666 results.
25. BNI; PROFESSIONAL DEVELOPMENT/; 4837 results.
26. BNI; (competen\* OR skill\*).ti; 3097 results.
27. BNI; 23 OR 24; 3846 results.
28. BNI; 25 OR 26; 7635 results.
29. BNI; 27 AND 28; 105 results

#### Search History

1. PsycINFO; ALZHEIMERS DISEASE/ OR exp DEMENTIA/; 36998 results.
2. PsycINFO; exp CLINICAL METHODS TRAINING/; 13163 results.
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15. PsycINFO; exp HEALTH PERSONNEL/; 75929 results.
16. PsycINFO; 6 AND 13 AND 15; 53 results.
17. PsycINFO; 8 OR 16; 73 results.



## Appendix 2: Interview Schedule Key Clinical Leads

- What training have staff had or is available to staff?
- Are there any gaps in the way your team functions that would help to identify training needs?
- What would you like to see in future training?
- There is some research to suggest training is not always effective for improving quality of care can you speculate why this might be?
- Do you have any suggestions for improving outcomes?
- We are trying to identify competencies and skills staff require to provide high quality care for people with dementia. What do you think these competencies might be?
- Do you think there is anything missing from this framework (A copy of the competency framework developed Stafford University is presented)

### Appendix 3 Notes Interviews with Key clinical Leads: Example of Handwritten

#### Notes

using influences  
• level of knowledge ↑.  
Ability to be boundaries  
care business. promote this  
good understanding other organisations  
understanding boundaries of work  
personal boundaries.  
self care.  
research skills. evaluation intervention  
introduce new interventions & evaluate  
it.  
Working Therapeutically Therapeutic  
approaches.  
Ability understand what therapeutic  
approach in order to achieve particular  
goals.  
skills might employ.  
Range of therapeutic approaches -  
practical purposes.  
Psychodynamic Thinking. Attachment  
Theory. Integrative approach.  
Awareness of informed consent. } x 2 dis  
Assessment of capacity. } or  
ONAAAS. Pre-assessment counselling  
skills. Informed consent.  
what does this mean.  
Attitude.  
age gaining risk.  
knowledge of legislation - confidence to  
use this. comfort around healthy risk  
deprivation of liberty. How is ability  
to apply this.  
emotional challenging emotions  
old difficult emotions. } Staff  
Extremely. - self reflect. } can't do this  
respond appropriately.  
depression techniques.  
knowledge of limits.  
reflective practice.

Psychology -> Evaluating CST.

for younger people with dementia,  
leading for well-being  
group approaches.

Information ~~given~~ given to people at  
early diagnosis.

Partnership with Alzheimer's Society  
Alz's Care.

Ongoing support - continue to consider  
to what they have learnt

not culture of reflective practice  
training without consultation frameworks  
champions things taught in training  
supervision group at Hollyhill  
ongoing supervision need.

meaningful.

create culture reflective practice  
learn & develop skills.

culture reflective practice -  
space... understand value  
practise. Need to identify staff  
who are able to provide reflective  
practice approach.

\* Supervisor -  
development competencies  
Standard self care caring for  
staff members.

Managerial not.

Clinical supervision - productivity  
care for self "we need supervision"

No established diagnosis

presentations complex

financial

relationship / social difficulties

personality difficulties

knowledge & understanding

-> differential diagnosis  
understanding of how dementia  
expresses in self.

#### Appendix 4: Staff Questionnaire

##### Dementia Workforce Project: Competencies required for Staff Working within Specialist Dementia Services

.....Mental Health Services for Older People are seeking to identify the training needs and competencies for staff working within specialist dementia services. This is in order to equip staff with the necessary knowledge and skills so that they are able to ensure people with dementia receive the highest possible care. We are currently undertaking a short survey of staff working with the division.

Please complete the questions below based on your own understanding of the role of staff working within specialist dementia services.

##### Question1.

Please identify 3 *common/generic* competencies and/or skills which you feel are important for staff working with people living with dementia and their families.

(The term “Generic” is used to define competencies and skills that all staff working with people who have dementia should have).

- 1) .....
- 2) .....
- 3) .....

##### Question2.

Please identify 3 *specialist* competencies and/or skills which you feel are important for staff working within specialist dementia services?

- 1) .....
- 2) .....
- 3) .....

##### Question3.

What makes my practice different from somebody working with people who do not have dementia?

.....  
.....  
.....

#### Appendix 5: Focus Group Interview Schedule

- Warm up question
- What roles do you have? What do you spend your time doing?
- What sort of sort of skills do you need to do your job?
- You are working within a specialist service, what do skills or knowledge do you have which makes you different from somebody working in a non-specialist setting.
- Looking back at the past week what type of training would have been helpful?
- Are there any gaps in the way your team functions that would help to identify training needs? (Prompts-Hygiene/physical care, behaviours that challenge, palliative care, difficult relatives, managing your emotions, working alongside colleagues)
- Thinking about the training you have had in the past what was the most useful and what was the least useful?
- What would you like to see in future training?
- There is some research that demonstrates that training is not always effective in improving quality of care. Can you speculate about the reasons for this? (Prompts? Staffing levels, attitudes of colleagues, philosophy of ward/unit)
- Do you have any suggestions for improving training outcomes?
- We are developing a competency framework what do you think should be included?

Appendix 6: Consent Form

5/07/10

Carer Consent Form Version 1

*Title of the project: A project to examine the key competencies required by specialist mental health staff working with people with dementia.*

1. I confirm that I have read and understood the participant information sheet dated 12/02/2010 version 1 for the above study and have been given a copy of the participant information sheet. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights.

☐

3. I understand the purpose of the project and what my involvement will be.

☐

4. I understand that the interview will be recorded and that anonymous quotes from the group may be used in reports and publications.

☐

5. I agree to take part in the study.

☐

Name of participant.....

Date.....Signature.....

Name of project worker.....

Date.....Signature.....

## Appendix 7: Focus Groups

### Participants Included:

Assessment Functional	3 HCAs
Continuing Care	9 HCAs
Assessment Functional	13 HCAs and 2 Qualified Staff band 5-7
Continuing Care	1 band 6, 1 band 5, 3 HCA's
CMHT	4 band 6
Assessment Organic	3 HCAs
Assessment Organic	3 band 5, (2 newly qualified)
Learning Disabilities	8 staff mix of professional backgrounds
Assessment Functional	1 band 5 and 1band 6
Black and Minority Ethnic Community Interest Group	1 band 8, 2 band 6/7
Occupational Therapy	4 band 6
Assessment Organic	2 band 5
Physiotherapy	7 band 5-7
Occupational Therapy	5 band 4
Carers Group Continuing Care	10 carers 2 staff
Carer Group Dementia Council	4 Carers 2 staff

## Appendix 8: Staff and Carer Information sheets

### Participant Information Sheets

#### Carer Information Sheet

5/07/10 Version 1

*A project to examine the key competencies required for specialist mental health staff working with people with dementia.*

#### Information form for Participant

You are being invited to take part in a research project. The aim of this information sheet is to explain the aims of the project and how you would be involved if you decided to take part. Please take the time to read the information sheet carefully. Talk to others about the study if you wish. Please contact a member of the project team if there is anything that is not clear or if you have any questions.

#### What is the project about?

Analisa Smythe, a member of the project team from Birmingham and Solihull Mental Health Trust is carrying out focus group interviews to find out about what sort of skills are needed by health care professionals who work with people with memory problems and their carers.

#### What will happen if I take part?

We are asking people who care for people with memory problems to take part in a focus group.

We will ask you about your experiences in caring for a person with memory problems. We would also like to know about the sorts of skills which you think professionals who work with people with memory problems and their carers should have. There are no wrong or right answers. We simply want to hear your opinions.

The interview will last about an hour. They will be recorded so that we do not miss anything and later be transcribed so that it is anonymous. The recording will be stored in a locked cabinet in the research office and will be destroyed when the study is completed.



It is important for you to be assured that all the information will be treated confidentially and will only be seen by members of the project team. Quotes from the focus groups may be used in the presentation of findings, but these will be anonymous. The report of the study will not include any details about you.

#### Do I have to take part?

No. It is entirely up to you whether you participate or not.

#### Benefits of taking part

We cannot promise the project will help you but the information we get from this project may help improve the care of people with dementia.

#### What happens if things go wrong?

If you have any concerns about the study, you should ask to speak to Analisa Smythe Tel. 0121 301 2069 who is based at the Barberry centre, Vincent Drive, Edgbaston, Birmingham.

#### How to complain

If you remain unhappy and wish to formally complain, you can do this through the Trust's Complaints Procedure.

#### Who is organising the research?

The project is funded by the Strategic Health Authority (SHA) and it is being carried out within Birmingham and Solihull Mental Health Trust, Mental Health Services for Older People.

#### Contact details of the research team

The name of the person in charge of the study is Dr. Nicky Bradbury, Psychology Lead/Clinical Director, MHSOP. Dr. Bradbury can be contacted on 0121 685 6422.

Thank you for considering participating in this study.

12/02/2010 Version 1

Staff Member Information Sheet

A project to examine the key competencies required for specialist mental health staff working with people with dementia.

Information form for Participant

You are being invited to take part in a research project. The aim of this information sheet is to explain the aims of the project and how you would be involved if you decided to take part. Please take the time to read the information sheet carefully. Talk to others about the study if you wish. Please contact a member of the project team if there is anything that is not clear or if you have any questions.

What is the project about?

Analisa Smythe, a member of the project team from Birmingham and Solihull Mental Health Trust and Cathy Jenkins, a senior lecturer at Birmingham City University, are carrying out focus groups to find out about training needs and how training should happen in the future. We would also like to know about what kinds of skills you think are important when caring for somebody with dementia.

What will happen if I take part?

We are asking staff to participate in small focus groups which will take place at your place of work. We will ask people who take part in the groups to talk about their experiences and discuss ideas with other members of the group. There are no wrong or right answers. We simply want to hear your opinions.

The focus groups will last about an hour. They will be recorded so that we do not miss anything and later be transcribed by a member of the project team. The recording will be stored in a locked cabinet in the research office and will be destroyed when the study is completed.

It is important for you to be assured that all the information

will be treated confidentially and will only be seen by members of the project team. Quotes from the focus groups may be used in the presentation of findings, but these will be anonymous. The report of the study will not include any details about you.

#### Do I have to take part?

No. It is entirely up to you whether you participate or not.

#### Benefits of taking part

We cannot promise the project will help you but the information we get from this project may help improve the care of people with dementia.

#### What happens if things go wrong?

If you have any concerns about the study, you should ask to speak to Analisa Smythe Tel. 0121 301 2069 who is based at the Barberry centre, Vincent Drive, Edgbaston, Birmingham.

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The project is funded by the Strategic Health Authority (SHA) and it is being carried out within Birmingham and Solihull Mental Health Trust, Mental Health Services for Older People.

#### Contact details of the research team

The name of the person in charge of the study is Dr. Nicky Bradbury, Psychology Lead/Clinical Director, MHSOP. Dr. Bradbury can be contacted on 0121 685 6422.

Thank you for considering participating in this study. I am sending your manager a list of dates and times when we will be conducting the focus groups. Please ask your manager if you are interested in taking part.

Appendix 9: Researcher CV

**CIRICULUM VITAE**

## Appendix 10: Extract from reflective Diary

### January 2010

Just conducted the first focus group on continuing care unit. Feeling a bit shell shocked! The staff who took part were all Health Care Assistants. They seemed a little reluctant to talk at first but really opened up as the group went on. I think it helped that I was from a different department (R&D) rather than the Mental health Services for Older People Directorate (MHSOP). It was difficult to keep on track at times with regards to following the interview schedule but it really helped having.....co-facilitated the group. ....also came up with some really interesting prompts to explore what the staff had said in the group such as person-centred care not working in practice.

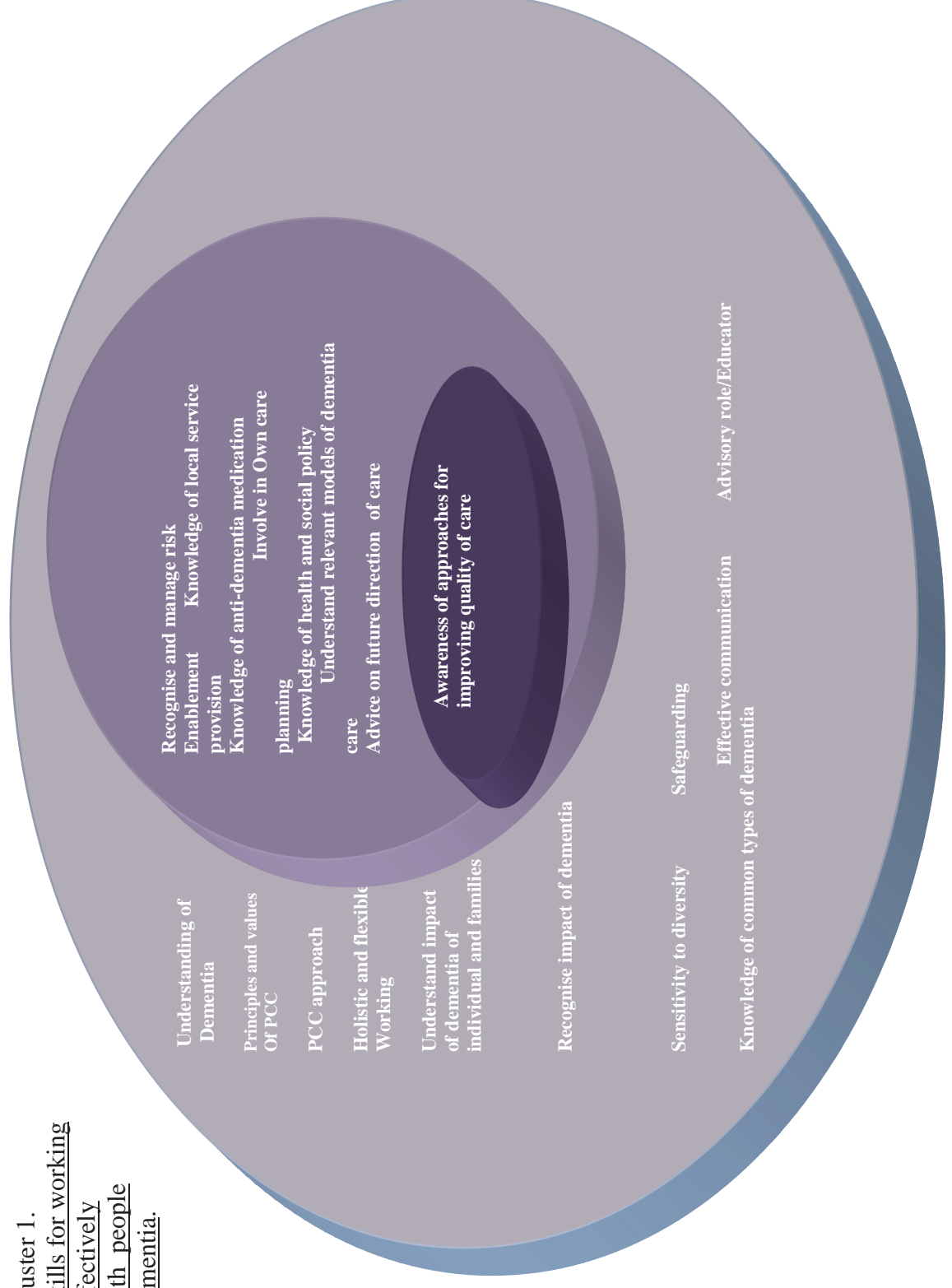
The most disturbing part of the group was when staff talked about how they were frequently subjected to incidents of violence and aggression. One participant described an incident when a patient had hit her in the jaw while she was assisting him in the bath. She said the noise was so loud other staff could hear it from outside. She also said that she had not filled out an Incident Report form (IRIS) following this incident. It seemed as if this was seen as a bit of a “waste of time” and that they didn’t really appreciate the reasons why you might need to fill out this form. This might be a clinical governance issue, must make a note to discuss this in clinical supervision. It struck me that the staff felt that being “hit...kicked...punched” was as part of their role. Obviously they are managing patients with challenging behaviour but they accepted this at face value, labelling or thinking of the patients in terms of being difficult rather than looking for alternatives for the behaviour.

Both .... and I were heartened by how caring the staff seemed to be, with regards to both the patients and each other, team work was seen as really important. It came across how incredibly dedicated the staff are despite the very difficult circumstances and how important they felt that their job was. The group described themselves as “mature” and said that they worried who would “take over” from them when they retired.

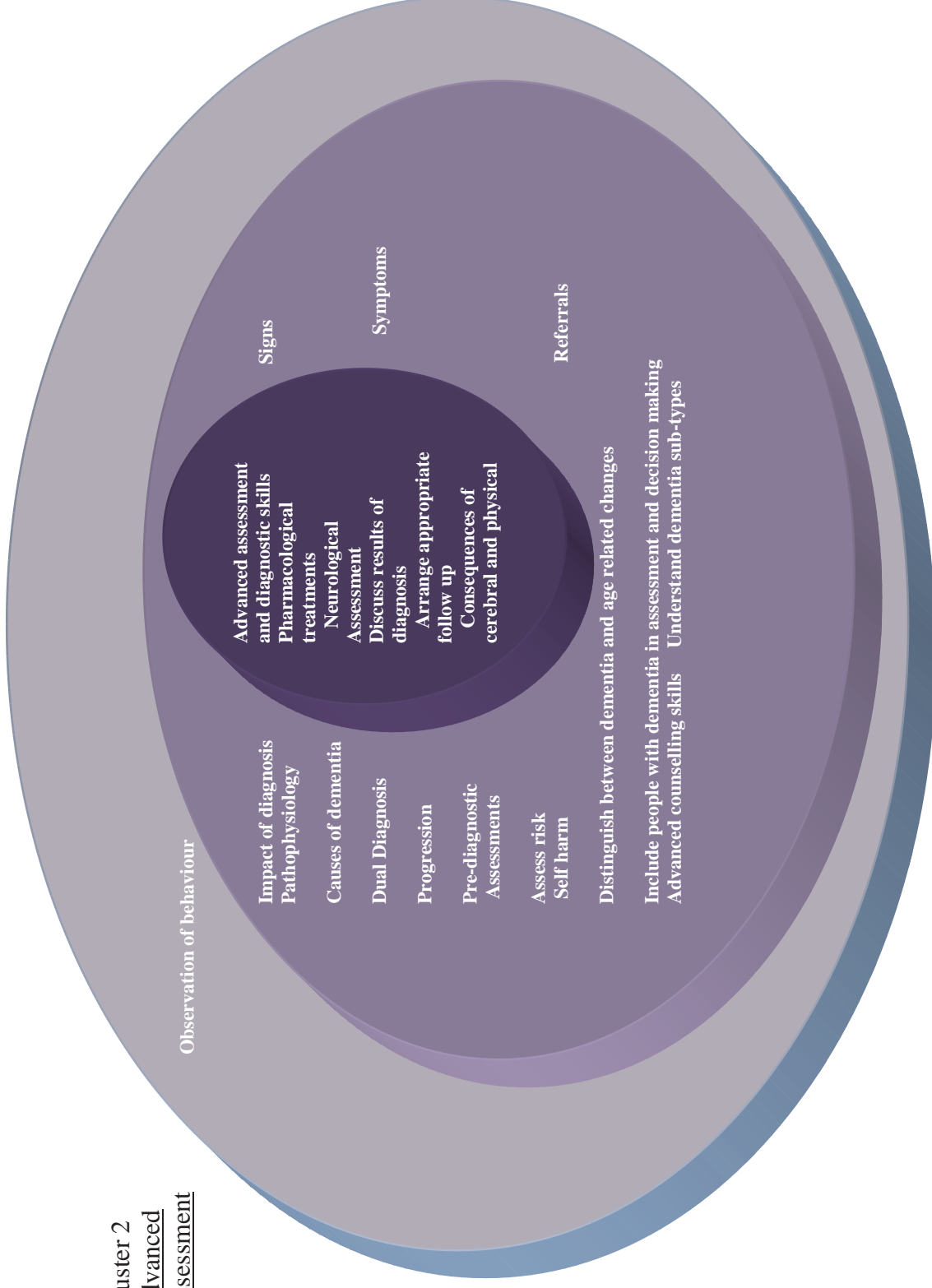
## Appendix 11:Cluster Diagram

Competency clusters 1-8 Figure 3  
 Key 1-5 Generic Grey outer circle 4-5 Specialist/Advanced Lilac Middle circle 5 Advanced Purple circle

Cluster 1.  
Skills for working  
effectively  
with people  
dementia.

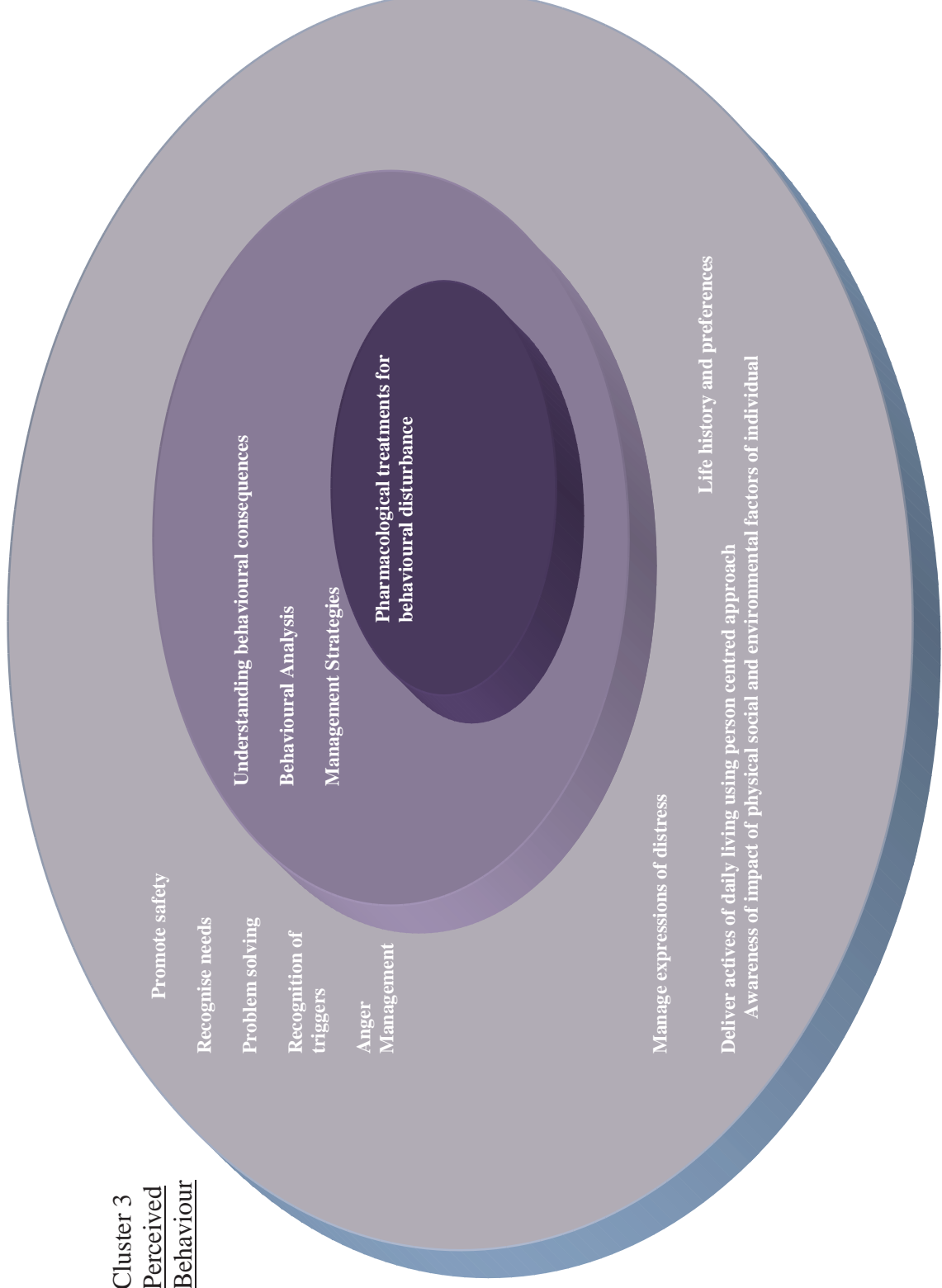


Cluster 2  
Advanced  
Assessment



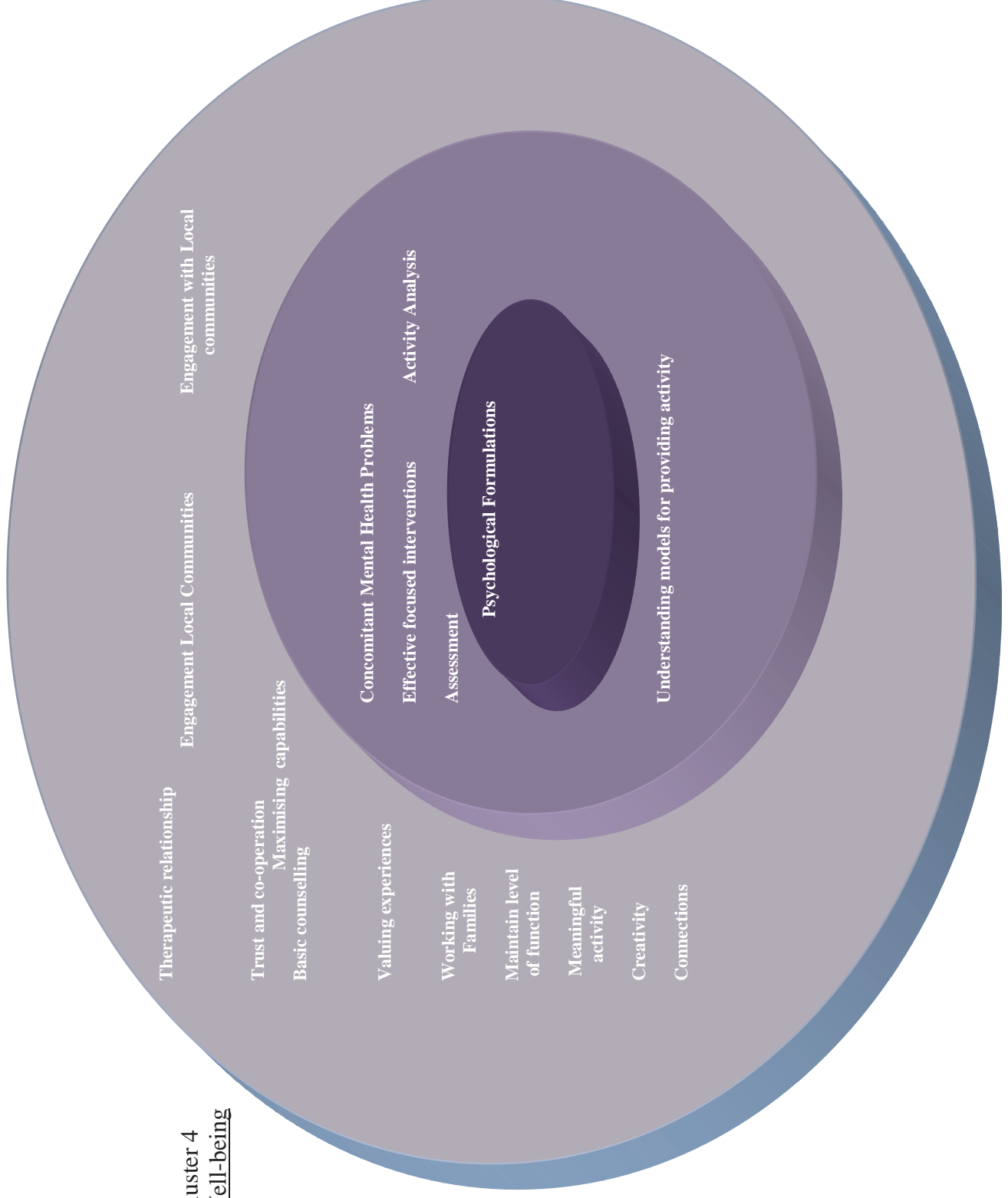


Cluster 3  
Perceived  
Behaviour

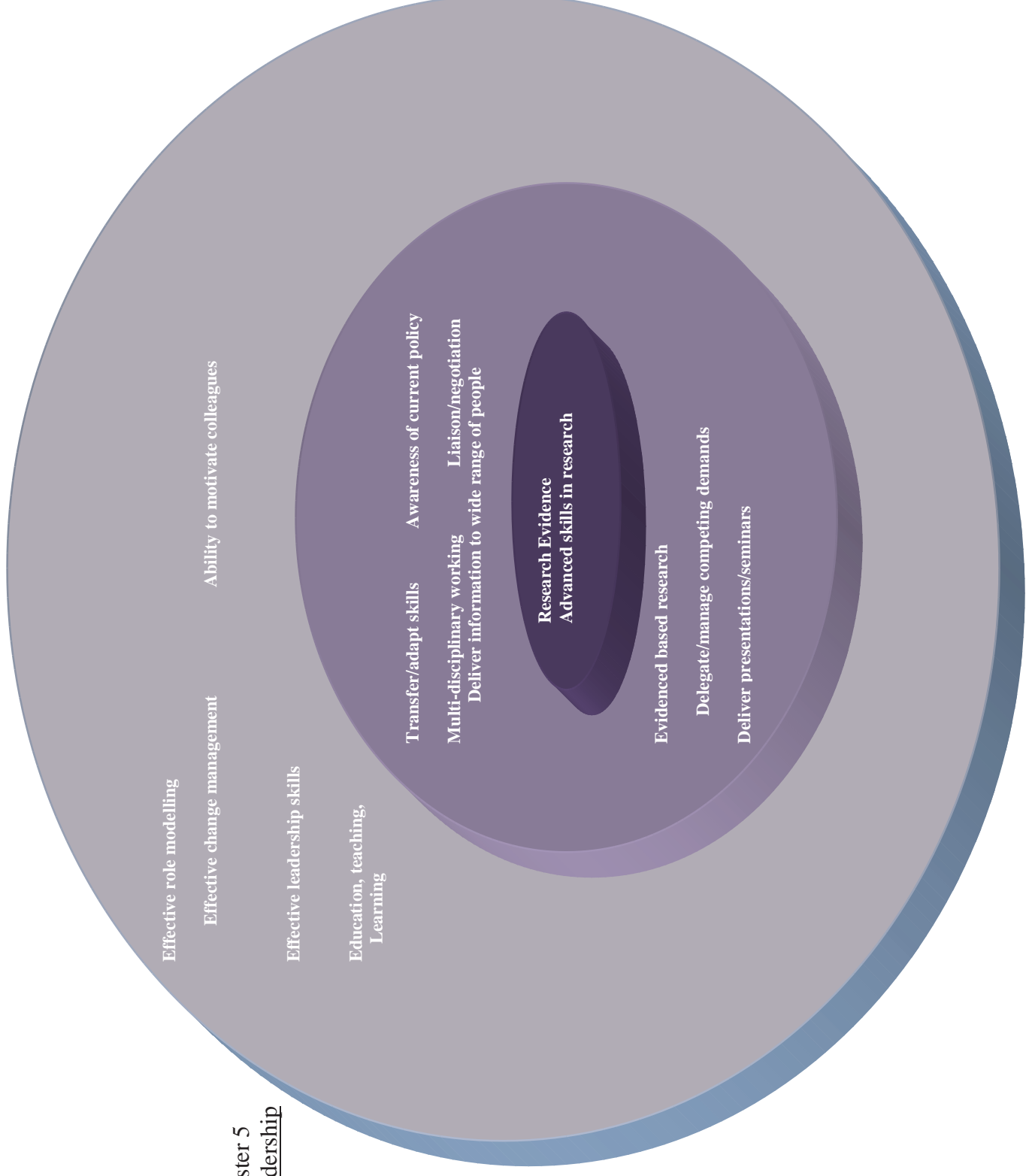


## Cluster 4

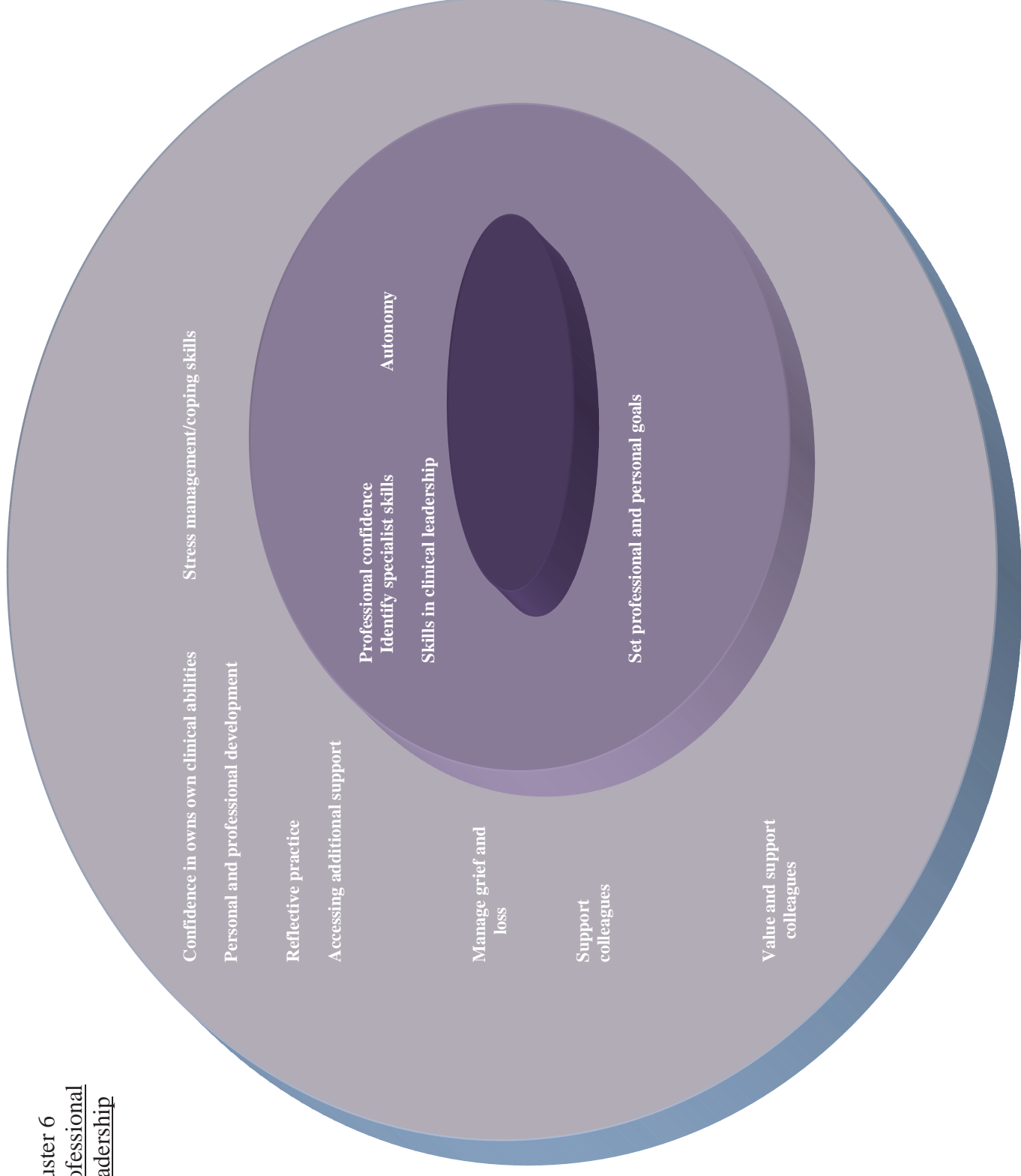
### Well-being



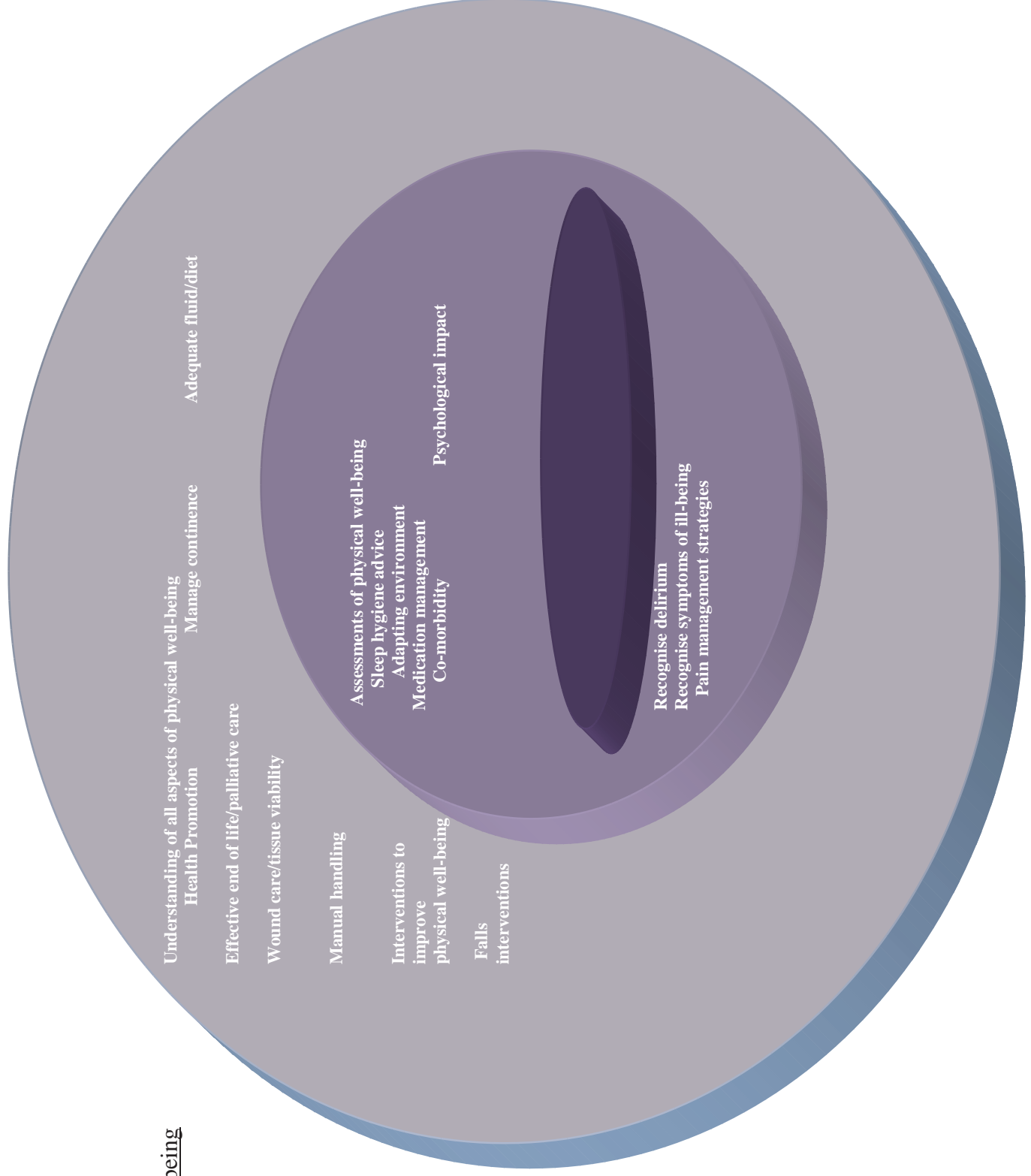
## Cluster 5 Leadership



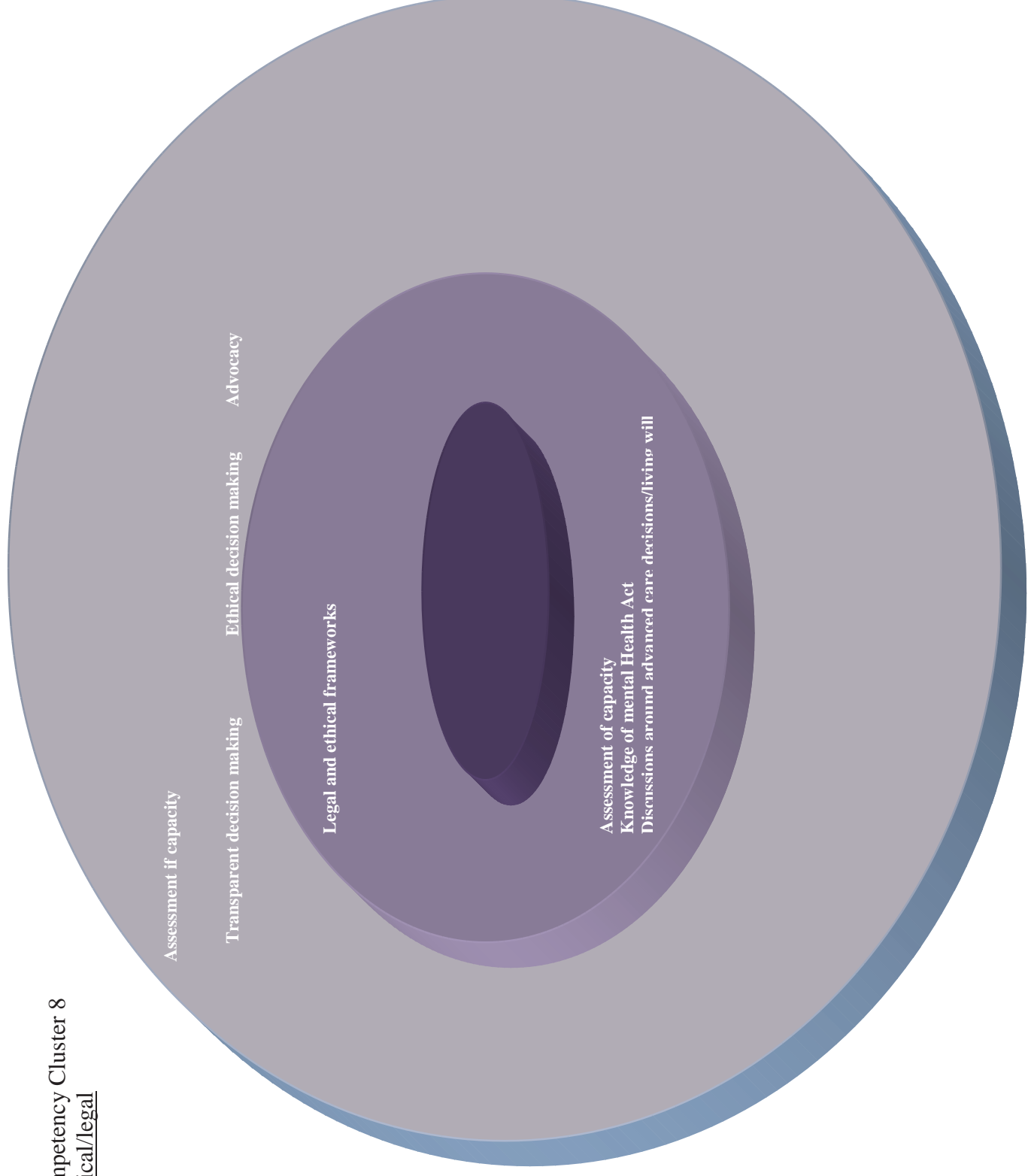
Cluster 6  
Professional  
Leadership



Cluster 7  
Physical Well-being



Competency Cluster 8  
Ethical/legal





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